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Alcohol debate intensifies

Mounting death toll versus civil rights

By Gary Seidler

TORONTO — "Dimensions of the human tragedy" of road deaths caused by drinking will have to be weighed against the "serious question of civil liberties" when Ontario considers recommendations which would allow police to suspend a driver's licence for 24 hours on a "suspicion" he had been drinking.

Attorney General Roy McMurtry made the comment after endorsing a report prepared by four government officials who studied 24-hour suspension programs in Alberta and British Columbia and a Check-Stop program in Alberta.

The report advocates similar programs for Ontario with certain differences designed to overcome deficiencies of the other provincial programs.

Mr McMurtry, who has placed drinking-driving problems high on his priority list, strongly supported the report's conclusions and recommendations. However, he did express concern that the plan would "widen police discretionary powers.".

The study group recommended police be given the power to suspend a driver's licence for 24 hours if they "reasonably suspect". he had been drinking and to take away his car keys to enforce it. A breathalyzer test would not be necessary.

They also recommended police use random roadside checks, even when there is no evidence of drinking, to increase "fear of detection".

Fundamental to any new preventive program, says the report, is the necessity for enforcement procedures to be preceded and accompanied by a public education program.

"The two countermeasures (i.e. the 24-hour licence sus-

(See — 24-hour — page 2)

A timely counterbalance to high holiday spirits was a province-wide campaign to educate the public about the potential hazards of drunk driving launched in December by Ontario's Attorney General, Roy McMurtry. Wrecked cars were strategically placed throughout Toronto to illustrate the $30,000 crusade which included posters and leaflets.

Drinking age: a dilemma for Ontario

TORONTO — The Province of Ontario may become the first jurisdiction in North America to rescind an earlier decision and raise the legal drinking age.

Suddenly, almost four years after adopting a continental trend and lowering the drinking age to 18 from 21, a crusade to raise the age — either to 19 or all the way back to 21 — has been gaining momentum.

— See editorial page 8 —

Since the October death of a 15-year-old boy from an alcoholic overdose, elected officials of both municipal and provincial governments have been gathering steam which has been reflected by daily newspaper accounts and public reaction.

Specifically, Ontario's new Attorney General Roy McMurtry has suggested the drinking age be increased to at least 19 years to remove many of the problems now associated with student alcohol consumption during the school day.

(See — Province — page 2)

Researcher to head NIAAA

WASHINGTON — Dr Ernest P Noble has been appointed the new director of the US National Institute of Alcohol Abuse and Alcoholism.

He takes the place of Dr Morris E Chafetz who resigned September 1 last year. Dr Noble, who is expected to take up his post early in the New Year following approval of the appointment by the US Civil Service Commission, comes from the University of California at Irvine where, for the last four years, he has been professor in the department of psychiatry and human behavior.

He also held the posts of professor of psychobiology and of pharmacology at the university and was director of neurochemistry at the College of Medicine. Dr Noble also served as staff psychiatrist at the Orange County Medical Center.

Announcing the appointment, James Isbister, adminis-

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INSIDE...

Alcohol in industry

Employee programs-cost effective

By Betty Lou Lee

CHICAGO — Employers who introduce alcoholism rehabilitation programs for their workers can expect to recover the costs of the programs within two years, even if they pay for all the treatment services themselves.

The cost will be recovered in reduced absenteeism alone.

This is the conclusion of a cost-benefit analysis done by the School of Hygiene and Public Health at Johns Hopkins University in a program that involved unions and management in 12 companies employing 134,000.

The three-year study was started in 1972, and financed by the federal labor department's office of research and development.

Economist Carl J. Schramm of Johns Hopkins, who presented the results to the annual meeting of the American Public Health Association, said in an interview: "We can now say to the world that if you start such a project, whether it be one employer or union or a joint effort, you can expect it to be cost effective for the employer even if he pays the whole cost."

In the Baltimore project, where the cost for 206 referred patients was $230,000, the 12 employers saved $454,000 in reduced absenteeism the first year of the program and $600,000 the second year.

Dr Schramm expects those savings to be $1 million in this third year of the study, "and those savings will continue to grow geometrically".

The treated workers lost an average of 445 hours from work in the 12 months prior to treatment, and 263 in the 12 months following their referral. This is in spite of an increase in absenteeism in the first four months after referral, often because of a "last binge" phenomenon that accompanied treatment.

The study team calculated that even if absenteeism among these workers remained at this level of 263 hours a year (compared to the 74-hour average of other workers), by the third year since referral, the employer would be getting a return of $1.36 for every dollar he invested in that worker's rehabilitation.

(See — Industry — Page 2)

BC Commission in jeopardy

By Tim Padmore

VANCOUVER — The crushing defeat of British Columbia's NDP government has left agencies, commissions and crown corporations here rife with uncertainty.

One of the more uncertain is the province's innovative and controversial Alcohol and Drug Commission.

The two-year old Commission has been the target of bitter attacks by Members of the Legislative Assembly, who are now likely to land important cabinet positions in the new Social Credit government.

The Commission's ideology, with its emphasis on voluntary community-based treatment service, is incompatible with the hard-line approach.

And, the Socreds have promised across-the-board "budget responsibility" and committed themselves to eliminating non-elected boards and commissions.

If the Commission is in danger, its chairman, Peter Stein, is doomed.

Mr Stein, a former member of the Le Dain Commission and, before he came to BC, assistant director of the Alberta Alcoholism and Drug Abuse Commission, is also a long-time friend of defeated Human Resources Minister Norm Levi, the man who gave him the chairman's job.

Says Mr. Stein: "I can understand why they might consider me a political appointee. But I'm less concerned with my personal position than with my hope the new government will take a reasoned look at the commission."

BC, with more than half of Canada's heroin addicts and the country's highest per capita alcoholism rate, has "the bare minimum" of services and indiscriminate slashing could do serious harm, Mr. Stein told The Journal.

The Commission grants funds to and sets standards for nearly 70 local agencies and programs, many of which predated the Commission.

Government report

24-hour suspensions proposed

(Continued from page 1)

pension programs and the Check-Stop program) are complementary and should be introduced concurrently.

"Together with a public education program, these three components should constitute a single package" to deal effectively with removing drinking drivers from the road.

Mr. McMurtry told reporters he hoped to introduce legislation next spring. He said it was "totally warranted" because of the highway slaughter caused by drinking drivers.

The report noted 44,983 Ontario drivers (1.13% of Ontario's driving population) were charged with drinking-driving offences in 1974 and that police recognize they are not even scratching the surface.

To increase the number of drinking drivers being stopped, and at the same time avoid overloading the courts and prisons, the report calls for a new form of action — action which would remove the offender from the road in such a way that he need not be processed through the courts.

The study group pointed out that both countermeasures are necessary to balance the objective probability (real chance) of a driver being stopped with the subjective probability whereby there is an increase in the driver's perceived chances of being caught.

The report also concludes that the effectiveness of any enforcement program is dependent upon the public's being made fully aware of the following:

- The threat which the impaired driver poses to the public both in terms of social costs and human suffering;
- The frequency with which drinking-driving occurs;
- The legal perimeters of impairment (i.e. of both federal and provincial laws);
- The effect of alcohol on one's ability to drive and how much alcohol will make a person legally "impaired";
- The consequences of being detected, charged, and convicted of a drinking-driving offence and why these consequences are fair and just in view of the seriousness of the drinking-driving problem; and
- The need for government to intervene to a greater extent than at present.

"In addition," the report says, "the public must be made aware that greater enforcement of drinking-driving laws is about to take place. This awareness must be continually reinforced.

"We are of the strong view that increased enforcement which is not preceded by and accompanied by a massive public education program will not only be countereffective, but will be met with public resentment rather than public support.

"Similarly, any media program which suggests that enforcement will be increased is useless unless accompanied by an actual increase in enforcement."

While the study group was impressed with the 24-hour licence suspension programs in British Columbia and Alberta, it suggested means to improve the effectiveness of an Ontario-adopted model.

The report calls for training programs for police officers to ensure that suspensions are not abused in such a way as to reduce the deterrent effect of the existing drinking-driving provisions set out in the Criminal Code of Canada.

Because the British Columbia and Alberta experiences show that some drivers continue to drive even though their licences have been suspended, the study group suggests police be given the authority to confiscate the offender's car keys or, if necessary, to impound his vehicle.

The group also suggests that all 24-hour suspensions be recorded with the Ministry of Transportation and Communications to keep tabs on repeated offenders. People whose licences were suspended for 24 hours twice within a year would have to defend their licences before the Registrar of Motor Vehicles.

Following the tabling of the report, Mr. McMurtry expressed his concern with increasing police powers to the level recommended.

Since police would need only "reasonable suspicion", not proof, to suspend a licence for 24 hours, there is the possibility of "reprehensible use of arbitrary powers," he admitted to reporters.

But, he added, the average blood alcohol reading of people charged with impaired driving has been 1.17%, almost twice the legal limit of 0.08%.

"Police officers obviously have erred very dramatically in favor of the accused . . . there is evidence many people's ability to drive is impaired to a certain extent when the level is below .08. What we are trying to do is bring in the borderline cases."

(The report was prepared by Howard Morton, of the Attorney General's department, Chief Superintendant W. J. Bolton, of the Ontario Provincial Police, and David Hieatt and Tony Cuncliffe, of the Ministry of Transportation and Communications).

US health insurance

Implications for drug programs

By Milan Korcok

NEW YORK — If and when national health insurance becomes a reality in the United States, its impact on existing drug treatment and prevention programs can be significant, says Dr Joyce Lowinson, Chairperson of the 1976 National Drug Abuse Conference.

Traditionally, health insuring agencies have been quite specific about the types of services that qualify for reimbursement. This has tended to favor alcohol and drug programs structured upon a medical model.

But given the heterogeneous nature of much drug programming, Dr Lowinson reflects growing concern about how therapeutic communities and less medically-oriented programs will fit into a national health insurance scheme.

The matter is of such urgency that a special interest track on third party payments and their impact on the training of personnel and accreditation of programs has been built into the forthcoming conference, to be held in New York in March.

Dr Lowinson notes that drug programs have the potential to do a lot in the way of prevention and education at the community level.

"But how can we be sure that the third party paying agencies which are part of national health insurance will agree that such initiatives are critical to good drug programming?

"Furthermore, how will they define which individuals are qualified to provide reimbursable services?

"Will the payment criteria continue to favor the medical model." asks Dr. Lowinson. "If so, we have to consider what may happen to many outreach programs."

At the present time, Medicaid regulations in New York State specify that physicians must be on hand at a program site for a given number of hours before the services of that program are reimbursable. Medicaid now funds close to one half of all publicly-funded non-alcohol drug programs in the state, and it does not cover drug-free programs.

If these are to become the critieria under a much broader national health insurance program, the implications for treatment are vast, says Dr Lowinson.

There is also the prospect of confidentiality to be considered, says Dr Lowinson, who notes that once government takes over the regulation of health insurance it can be expected to take over treatment records as well.

Province out to tackle drinking age problem

(Continued from page 1)

At the same time, Mr. McMurtry would like to see the driving age raised to 18 from 16.

However, the attorney general may have a tough time convincing Ontario Premier William Davis to accept such a move.

The Conservative government, supported both Oppositon parties, lowered the drinking age to 18 in 1971 in what many considered a vote-catching technique. Certainly, the move was widely supported.

Complicating the legislative process, should the government decide to reverse its decision, is the fact that the 1971 decision was part of a trend towards defining the age of majority at 18 and was one of 37 statues changed at that time.

Premier Davis indicated his own feelings in a letter entered as evidence at the inquest into the death of 15-year-old Walter Nehrenheim.

In his letter, Davis said it would be inconsistent to give 18-year-olds the right to marry without parental consent, the right to vote, and the right to enter into contracts, while denying them the right to drink alcohol.

Further, he suggested the solution to Ontario's student drinking problems lies in tougher enforcement of existing laws, not raising the legal drinking age from 18.

Noble named chief

(Continued from page 1)

trator of the Alcohol, Drug Abuse and Mental Health Administration, said: "We are most fortunate that Dr Noble has chosen to devote himself to public service at this time. His qualifications for the top US government post in the alcoholism field are extremely impressive. I am certain that he will distinguish himself in leading NIAAA as he has distinguished himself in his scientific career".

Dr Noble holds a PhD in biochemistry from Oregon State University in Corvallis, Oregon where he graduated in 1955 and an MD from what is now Case Western Reserve University in Cleveland, Ohio, which he obtained in 1962. He was a Fullbright Scholar at the Sorbonne in Paris in 1955-56 and held a Guggenheim Scholarship in 1974-75.

Early in his career, Dr Noble built a solid reputation with research studies on the metabolism of white blood cells, before he even elected to study medicine. Subsequently, while studying medicine, Dr Noble became interested in the problems of alcoholism.

Applying his biochemical knowledge he switched his research from leukemia to effects of ethanol in various laboratory animals. He has been especially interested in the effects of ethanol on neural tissue and in culture systems including alternations in ribonucleic acid metabolism in association with chronic alcohol intake.

After achieving his MD, Dr Noble trained in psychiatry at Stanford University School of Medicine in Palo Alto, California. He stayed on to become at first a research associate in the department of psychiatry and then assistant professor in the department.

In 1966 he spent a year at the National Institute of Mental Health working with Nobel Prize winner Julius Axelrod in the National Institutes of Health Clinical Center Laboratories in Bethesda, Maryland. Returning to California, Dr Noble took up an appointment as associate professor and chief of neurochemistry in the department of psychiatry and human behavior at the University of California, Irvine. His responsibilities here include coordinating the alcoholism research and training activities of a large group of scientists including faculty, post-doctoral and graduate investigators as well as the undergraduates.

Over the years, Dr Noble has been closely connected with US government efforts to combat alcoholism. He served as a member of the Alcoholism and Alcohol Problems Review Committee from 1969 to 1973.

He was a member of the task force that prepared the First Special Report to the congress on alcohol and health.

Industry can recover costs

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If the worker's absenteeism drops to that of the normal worker, the employer would be getting a $1.80 return for his dollar investment by the second year, $2.70 by the third year, and $3.60 by the fourth.

Dr Schramm said absenteeism was the only benefit analyzed, because it was the one that could be most easily measured. But he said there were at least eight other areas of potential benefit to the employer.

They include reduction of on-the-job accidents with their increased medical claims, equipment damage and material wastage; reduced labor turnover costs; and reduced costs for substitute labor.

"Alcoholic workers, often in the prime of work life, are expensive to lose and expensive to replace. By rehabilitating the individual worker, an employer can realize continuous productivity from these more senior and skilled workers, as well as savings in the area of recruitment and training of replacement workers."

Increased morale leading to increased productivity and better labor force stability, lower costs for grievance hearings and labor arbitrations, and lower medical costs for pathological conditions associated with alcoholism were other potential cost benefits.

In Baltimore, the 12-month treatment program for each employee cost an average of $1,300, including a $400 first-month cost for comprehensive physical and psychiatric examinations and assessments. The program included medical and counselling care, individual and group therapy, and involved 50 to 60 visits or sessions for the year. Dr Schramm suggested the average yearly cost could be reduced with increased numbers of employees involved.

The Baltimore project proved so successful that three groups competed to take over the whole clinic project in November — a management group, the local Alcoholism Council, and the Baltimore Metro Council of AFL-CIO. The governing board chose the AFL-CIO to own the project.

Dr Schramm said the study group worked with Maryland Blue Cross, and in October became the first in the country to offer coverage for outpatient alcoholism treatment services. Employers in Baltimore can now buy this coverage to reimburse the AFL-CIO for treatment of employees.

Newly-discovered chemical mimics morphine's actions ---clinical implications

By Jean McCann

ANN ARBOR, MICH. — The development of relatively non-addictive opiates now looms as a distinct possibility.

This was revealed here with the report of the discovery of a new natural brain chemical which mimics the action of morphine.

Dr. Sol H. Snyder, professor of pshychiatry and pharmacology at Johns Hopkins University School of Medicine, has baptised his new discovery "endorphin".

"Endorphin", he told **The Journal**, is a normally-occurring morphine-mimicking chemical in the brain, and has to do with nerves in the brain which have to do with the perception of pain."

The search for this presumed brain chemical began about two years ago, following discovery of the existence of opiate receptors in various parts of the brain — mainly in the lateral thalamus, the central grey matter, and in the limbic system.

Such a discovery, he said, "presumed the existence of a self-made morphine-like substance, since man is not born with morphine naturally occuring in him".

Now that the presumed morphine-like substance has been discovered, Dr Snyder said, the next step will be to determine the pattern of the amino acids in this peptide.

"We expect this to be accomplished shortly", he said, "because this appears to be a relatively simple peptide with only seven or eight amino acids.

"Also, since this is such a simple molecule, it should be relatively easy to synthesize several analogs of this peptide which could get into the brain and relieve pain. We could probably develop 300 such analogs in three months. It's also quite conceivable that they may be relatively non-addicting drugs.

The clinical implications of this are considerable", he said in an interview here during the meeting of the Council for the Advancement of Science Writing.

"For one thing, we need to know more about how pain is integrated, and since endorphin seems to be a neurotransmitter of pain-related neurons in the brain, once we can characterize how the endorphin system functions, we can understand a great deal more about pain perception."

In addition to the development of better pain-relieving drugs on this basis, Dr Snyder said, it may also enable something to be done about drug abuse.

"One can speculate that if analogs of endorphin are found, they might serve as substitution drugs for heroin addicts."

The psychiatrist - pharmacologist also told **The Journal** that even without endorphin analogs less addictive drugs of other types are on the market, or being clinically tested. These drugs have combined properties, being both agonists like morphine, and antagonists, like naloxone, which reverse the action of the opiates.

"Mixed agonists and antagonists are drugs that have some analgesic activity, but can also antagonize the properties of morphine, and thus tend to be less addictive. An example of this is pentazocine, or Talwin.

"In the US a number of drugs are being tested which have the properties of being both agonist and antagonist, but none are at the level of full Food and Drug Administration approval for clinical marketing", he continued.

"Some are at the advanced level of clinical testing, and some have been shown already to have much less addictive potential than currently-used opiates, although not completely free of it. Still, any opiate which is of less addictive potential represents an important advance."

Dr Snyder also noted that the new knowledge about the existence of opiate receptors in the brain has led to renewed speculation that there may be a genetic basis, at least in part, for addiction. A difference between individuals in the number and location of these receptors could also have something to do with differences among people in pain perception, he said.

Suzuki — "scientific information and research are too important to be known only by a select few"

Ethics, not science should come first

MONTREAL, QUE. — Old-fashioned thinking that alcoholism and criminal traits are in-bred, may come back to "haunt" society in this era of genetic manipulation.

The warning comes from Canadian scientist Dr David Suzuki, who says some researchers still believe in the possibility of selective breeding to eliminate inherent undesirable traits in some races.

"Some of North America's most outstanding geneticists are claiming it is every child's right to be born normal," said Dr Suzuki in an interview with **The Journal**.

"If we say every child has the right to be born normal, then obviously every abnormal child has *not* the right to be born," he emphasized.

Dr Suzuki, a zoology professor at the University of British Columbia said scientists in the '70's are aware of their fantastic powers to control and manipulate because of advanced knowledge in human biology.

Historically, such prominent American families as the Rockefellers and Harrimans have supported research indicating poor people to be inferior. Group sterilization has also been considered, Dr Suzuki said.

"Such ideas are pushed by people who know they are not going to be sterilized."

That kind of thinking has led to conclusions which indicated Blacks were inferior, he added. And, virtually every immigrant group coming to North America has been considered to be of low intelligence or class.

"Not so long ago, a former president of the Canadian Medical Association suggested we sterilize people before they receive welfare checks," Dr Suzuki said.

"I think people with high IQs, (Intelligence Quotients), who are in positions of power want to confirm their own superiority. It becomes self-fulfilling. When the teacher finds the child to have a low IQ, he is treated differently."

Suzuki said there is "no way" IQ can be equated with intelligence, creating groups of superior and inferior people.

A built-in element of racism exists in these arguments," said Dr Suzuki, "whereas ethical considerations should be of prime importance."

Dr Suzuki, who recently reduced his own laboratory work to become a "communicator," believes scientific information and research are too important to be known only by a select few.

"I think science has been mystified," he said. . . . "We should question that kind of power and authority."

"Is life getting any better within the milieu of scientific advances?"

Getting addicts into treatment

Force: a powerful motivator

TORONTO — Force is an effective way of motivating addicted people into treatment.

So says Jerry Danic of the Addiction Research Foundation of Ontario, Sarnia office.

"You can force people into treatment and have good results," Mr Danic told the 33rd Annual Convention of American Marriage and Family Counsellors in Toronto recently.

"In the treatment of addiction, the general problem of motivating people into some form of treatment is sometimes the most difficult part of the process."

That motivation takes several forms, explained Mr Danic.

The addict may be treated like a child, and someone, acting as the 'parent', forces the person into beginning the therapy process. This method is effective, said Mr Danic, because in many cases the addicted person is somewhat child-like in his dependency and behavior.

"Addicted persons act like children who have some pleasure they don't want to give up, like candy or TV. They are unable to look at the long-term consequences of their addiction, and so short-term pleasures come first," Mr Danic said.

Another motivation process involves "threatening" the addicted person with the loss of one of the things he still values.

In the case of an alcoholic spouse, the non-alcoholic partner may threaten to leave if treatment is not begun, Mr Danic said.

"Usually the threat by the non-drinker works only if he or she can become assertive enough."

Myths continue to hurt the treatment process, Mr Danic said. And the suggestion that an alcoholic won't respond to any form of help unless ready for treatment is not true.

"I'm even convinced . . . a forced hospitalization can work for many people who are in later stages of alcoholism and are unable to respond to any other type of treatment."

A second myth, Mr Danic said, involves believing the addicted person has to "hit bottom" before treatment can become successful.

"Sometimes we don't have the knowledge, skill or permission to apply the correct motivation . . . We lost them simply because we have not mastered some of the necessary motivational steps, or are afraid to apply the necessary force," Mr Danic concluded.

'Action against alcohol problems'

ALBANY, NEW YORK — Expansion of alcoholism treatment services, care for people now jailed for public intoxication, and increased efforts in alcoholism prevention, are called for in a just-released state task force report here.

Twenty major recommendations to strengthen New York's alcoholism programs are contained in the report, 'Action Against Alcohol Problems.'

In addition, position papers which describe the kinds of approaches needed to deal with such areas as alcoholism treatment methods and public education to prevent alcohol misuse are included.

Other recommendations include:

- insurance coverage of inpatient and out-patient treatment of alcoholism,
- increased company-union support for programs to help employees whose work is adversely affected by alcohol,
- "highly visible" information and referral services as part of local alcoholism programs, and
- studies on the prevalence and appropriate prevention and treatment of alcohol abuse among a number of "special" population groups.

The report will serve as the basis for the Department of Mental Hygiene's five-year plan for expanding the alcoholism and treatment programs to meet the needs of the state, according to Dr. Lawrence Kolb, chairman of the task force which produced the report. The report was completed in 2 years.

Copies of the task force report can be obtained from the Division of Alcoholism, New York State Department of Mental Hygiene, 44 Holland Ave., Albany, New York, 12229.

In early therapy period

Child complicates mom's treatment

Betty Lou Lee reports from the annual meeting of the American Public Health Association, Chicago

TREATMENT OF drug addicts is typically geared for men, and may not serve the needs of female addicts, particularly those who are mothers, a study of 45 such women shows.

Female heroin addicts are considered more deviant by society than male users. Women addicts bear the additional social stigma of participation in illegal activity, and their concept of themselves may have been seriously altered because of their sexual experiences.

More than half had engaged in sex for money, 38% had been involved in an incestuous sexual experience, and 58% had been raped.

The study was conducted in July, 1975 by Paul E. Ryser, PhD, and Paul D. Phillips of Richard Caton Associates, Rockville, Md (formerly Addiction Consultation and Evaluation), and Dr Jack N. Carr of New York. They collected socio-economic data from women in a psychotherapeutically oriented, drug-free residential treatment program for drug-using parents or parents-to-be.

"It was our hope that the aggregation of the data from female drug users might have some impact on the treatment provided for them," Dr Ryser said.

They averaged 23 years of age, with 11 years of education and 1.7 children. Forty per cent were on welfare when admitted, 53% were single, 29% married and 18% divorced or separated.

They first started using drugs at an average age of 15, and their first substances were alcohol and marijuana, used in a group situation.

Heroin was the primary drug for half the women, alcohol for 16% and amphetamines, 11%. Most of their use occurred with other people, a factor that may complicate their rehabilitation . . . "the inability of these women to change their peer group environment may contribute to difficulty in remaining drug-free".

The mere fact that 37 of the women were already mothers differentiates them from their male counterparts because males "are seldom considered to care for their children in the manner expected of mothers," Dr Ryser said.

In line with the male model which most drug treatment programs follow, "the patient, single or parent, is assumed to have split from the home and family. Thus, parenting aspects need not be a function of treatment." But children generally remain with the mother.

Added to the lack of parenting consideration in most treatment programs is the view that society, health care providers and the women themselves have of addict mothers.

Three-quarters of them derive at least some of their income from illegal sources, and 62% have been arrested at least once.

There may be lack of support by family in their attempts to stay drug-free, because there is a high rate of alcoholism, drug use, jail and psychiatric treatment among parents, siblings and husbands.

The underlying anti-social personality and behavior disorder of which drug use is a symptom is manifest in all areas of interpersonal behavior in these women, Dr Ryser said.

"Once the drug problem is 'solved' there remains a complex of unresolved personal and social problems . . . the treatment milieu must therefore address more than the symptomatic problems of substance abuse.

"The addict does not alter anti-social behavior because she becomes drug-free. Post partum she continues her behavior to the detriment of her child. Responsibility for the addict mother and her child rests with the helping professions."

This responsibility is shunned, Dr Ryser said, because the complexity of problems reduces the potential success for 'curing'.

The group recommended separate care for the mother and her children during her initial therapy period — her problems are so complex and acute the presence of the children only complicates them.

"In most cases, her depression and 'battered' self-concept need therapeutic consideration before she can contribute to the socialization of her children." Court-appointed guardians for the children during early treatment might be a possible solution, they suggest.

Millions of working people would benefit from industrial alcohol programs

THE PRESIDENT of the Drug Abuse Council Inc. has appealed to the American Public Health Association to help industries and unions tackle the alcohol abuse problem that is costing industry $20.7 billion a year — just one billion less than the whole 1974 federal health budget.

Dr Thomas E. Bryant said only 531 of the 1.5 million private corporations in the US have alcohol treatment programs, and there are even fewer programs for drugs other than alcohol.

He told the annual meeting of the APHA that 75% of the country's 85 million workers are employed by companies with fewer than 500 employees, where it is unlikely either unions or management will take the initiative in establishing programs.

Since alcohol affects the health and productivity of about 8% of a work force, probably 5.1 million workers in small businesses could benefit from rehabilitation programs.

Dr Bryant, who is both a physician and lawyer, called on the public health system to stimulate awareness of the problem among the public, employers and unions; to provide information on how to combat the problem, and also to provide referral and follow-up services, and to help provide treatment facilities where none exist.

"Most alcohol treatment programs connected to the work place report about 75% job rehabilitation — drug programs, 60% to 65%," Dr Bryant told the conference, whose theme was Health and work in America. He defined job rehabilitation as the worker being able to stop or control his drug use well enough to perform his job adequately.

"The connection with the work place — the threat to job security — seems to provide a powerful motivation to rehabilitation. If both labor and management agree to use this threat in a positive, not a punitive way, then it can become a powerful motivation tool.

"Secondly, the work place provides an opportunity for intervention, and early intervention. Within the work world, the employer has both the opportunity and the right to intervene if certain forms of behavior interfere with the employee's ability to perform his job.

"Using these two factors — the threat to job security as motivation, and the standard of poor job performance — a simple, but effective program can be set up. The concept behind the program has been called 'constructive confrontation'."

The Drug Abuse Council is a private independent foundation established in 1972 to do research, evaluate public policy and give program guidance. It does not give direct service.

It prepared a 53-page booklet, Alcohol and Drugs at Work, specifically for the APHA meeting, outlining the scope of the problem, giving examples of successful industrial treatment programs, and suggesting a bigger role for public health agencies.

In an interview, Dr Bryant said this emphasis on alcoholism represents a change in tactics for the council.

"We have always said that alcohol was the number one problem, but we have never had specific alcohol-related research projects.

"When we were created, the National Council on Alcoholism was operating, and the country was in a tizzy about heroin and marijuana. In the last few years, we've decided that was a bit of a cop-out, to pretend that alcohol is somehow different and deserves a special category."

With a country-wide cutback on social service budgets, it seems reasonable to get rid of as much overlap as possible, rather than having separate programs for alcohol and other drugs, he said.

"I don't know if we'll ever be comfortable together. For one thing, most alcoholics are employed and most drug addicts aren't, so we're coming at these problems from different directions."

Dr Bryant said he was "cynical and pessimistic" about most education programs aimed at preventing drug abuse, and called school programs in drug abuse "an abysmal failure".


Thomas Bryant

Increased lethality of narcotic addiction

Alcohol may be the factor

INCREASED MULTIPLE drug use especially with concurrent alcohol use may be the cause of an increase in the 'lethality' of narcotic addiction in recent years, a psychiatrist at a major New York treatment centre suggests.

In a three year study, Dr Alex Richman of the Beth Israel Medical Centre found that daily consumption of alcohol among narcotic addicts had increased 60% from 1972 to 1975.

One quarter of the 1975 patient population were also daily users of barbiturates, glutethimide and/or tranquillizers over the previous three months.

Such use was highest among women, younger whites, those with previous multiple admissions, and concurrent users of alcohol. It also increased with severity of psychological distress, reaching a peak of 46% among those with previous breakdowns.

The synergistic interaction of alcohol with narcotics may be an important factor in the morbidity and mortality attributed to narcotic addiction," Dr Richman suggested.

"Drug related deaths attributed to narcotics have significantly elevated blood-alcohol levels in 50% or more of the cases."

A recent follow up of 100 addicts first treated at his centre from 1961 to 1963 showed a 23% mortality rate up to 1975, and one half of these have occurred since 1970.

"This change in 'lethality' may be related to an increasing pattern of multiple drug use. With increasing age and duration of addiction, the increasing rate of alcohol use may be a major risk factor in drug related deaths."

Dr Richman noted that drug and alcohol authorities are separate agencies at the federal, and many state and city levels.

"There is [illegible] to develop integrated approaches for [illegible] treatment programs for the various clinical types of substance abusers, and to facilitate the epidemiologic understanding of the manifestations, correlates, course and outcome of the multiple patterns of narcotic addiction.

Follow-up studies are needed to differentiate whether 'new kinds of drug abusers are being seen, or whether the consumption of multiple substances reflects adaptation to the spectrum of currently available substances, rather than new consumers.

Although major efforts have been directed to [illegible] the availability of narcotics, the concomitant use of alcohol and other mood modifying substances presents an increasing problem among those narcotic addicts seeking treatment."

The [illegible]

In the 1972 sample of [illegible] patients, 27% had used alcohol daily in the previous three months. This had [illegible] to 41% by 1975. Alcohol use was greater among males, and increased progressively with age.

While there were some [illegible] and sex differences in the two groups [illegible] would lead to an overall [illegible] rate of alcohol use in the 1975 group, each demographic subgroup also showed higher alcohol use in 1975.

The [illegible]

[illegible]

Lloyd Fell

Executives need help too

By Karin Sobota

TORONTO — Corporation executives face a greater alcohol problem than factory laborers, according to Lloyd Fell, director of the Lifeline Foundation.

Nearly 50% of executives "drink too much" and the problem gets worse "the higher you get in the company," said Mr Fell.

A co-operative venture of the United Steelworkers Union of America, Lifeline was formed to help employees with drug and drinking problems.

Statistics taken from a 1972 survey of 35,000 workers show one out of 10 factory workers has a severe drinking or drug problem.

But, it rises to three out of 10 at the office and supervisory staff level, said Lifeline's director.

"We found the top executives to be consuming more in a 24-hour period than laborers... They have it in the office and they take two-hour lunches at which they entertain friends."

The factory worker, however, has a more difficult time drinking on the job because he can more easily be spotted by supervisor, Mr Fell went on to say.

Workers have turned to marijuana on the job because its smell is easily disguised among factory odors and foremen seem to be more tolerant of the habit, he said.

"Some of the over-35 workers are forming a cross-addiction. Marijuana is becoming the biggest problem in the factory and its use shows in workers' behavioral problems, inefficiency, carelessness and absences," Mr Fell said.

Survey figures which indicate a 2% a year increase in drug use are "modest". But the increase, he said, "is being held under wraps" by employees who cover up for each other.

Mr Fell , who attended a Toronto conference on Alcohol and Other Drug Abuse in the Work Place Conference recently, said another study is being planned for late 1976.

"We'll see the effects the Lifeline Foundation has had in the plant and we'll also be making a concentrated movement in the plant to train foremen and shop stewards so they can refer people who need help."

Senior executives will also be assisted — "a not too difficult task."

A problem however, is the method of referring a top executive for treatment, Mr Fell concluded.

"Nobody will go up to their boss and tell them he has a drinking problem, or that alcohol has caused him to make a mistake on the job."

$1 billion lost annually to alcohol

TORONTO — Alcohol-related on-the-job accidents cost Canadian industry $1 billion a year, according to the director of the Health and Safety Division of Ontario Hydro.

Dr Donald Grant says 2% - 3% of the industrial work force are alcoholics, functioning below their capacity, endangering fellow workers and plant equipment, hurting their families and shortening their lives.

Dr Grant and representatives of several corporation health departments were guest speakers late last year at the Alcohol and other Drug Abuse in the Workplace conference, which drew more than 200 delegates from government, business and industry.

Conference speakers concentrated on industrial accidents caused by alcohol and other drugs and emphasized the need to reduce the soaring financial and social costs induced by alcoholic employees.

The Hon. Michael Starr, chairman of the Ontario Workmen's Compensation Board, said $261 million in compensation benefits were paid to injured workers last year.

As is Ontario Hydro, some corporations are now stressing the value of "constructive coercion" programs within the company to deal with alcoholic and addicted employees.

This "carrot and stick" method referred to at the conference, forces the employee into seeking treatmcnt for his condition at the risk of losing his job. According to reports by Hydro, General Motors of Canada, and the Kodak Company of Canada, this program has achieved success.

Kodak has noted a 60% -70% recovery rate among its alcoholic employees who have undergone treatment, according to Dr John Hill of that company.

Hydro's control rate has been recorded at 63%, an increase of approximately 50% when a voluntary treatment program was in operation, according to Dr Grant.

Donald Grant

Winnipeg study shows

Anti-alcohol services sparse

By Manfred Jager

WINNIPEG — A spot-check has revealed services to alcoholics are difficult to obtain in Winnipeg, according to Jim Burdick, research director of the Alcoholism Foundation of Manitoba.

Mr Burdick said the spot survey, done last year and evaluated until now, shows that even in the inner city of Winnipeg, anti-alcoholism services are not available to all who need them.

Beyond the Winnipeg core, said Mr Burdick, alcoholics depend on their doctors and through them on hospital services for treatment and care in connection with their diseases.

Mr Burdick, a psychologist, said 500 copies of the 116-page report, dubbed *The November Survey*, have been produced at a direct cost of more than $10,000. The money does not include salaries for staff time expended in compiling and evaluating the information now distributed.

A similar study, examining alcoholism services for the entire province of Manitoba during June, July and August 1975, is in preparation. November Surveys are likely to be an annual event from now on, he said.

Mr Burdick said as authorities gain a comparative picture of the incidence and prevalence of alcohol abuse in the province, the dozen-or-so agencies treating the disease in Winnipeg, and others dealing with the problem in rural Manitoba, will become more effective in their work.

The first November Survey limits itself to stating what anti-alcohol agencies spent in six Winnipeg areas, and how many clients from each area were treated during November, 1974.

Agencies surveyed by the Alcoholism Foundation were: X-Kalay; the Salvation Army Rehabilitation and Detoxification branches; Alcoholic Family Services; the Native Alcoholism Council; Kia-Zan; Strabbrook House; Nassau House; River House; 124 Nassau Street; the Main Street Project; and 55 Lydia Street.

"The importance of the report is that before this there was no specific information about alcoholism services in Manitoba," Mr Burdick said.

"We had assumed that for one thing we were servicing Winnipegers as a whole. That has been proven in the survey not to be the case. We are in fact servicing a very small area in Winnipeg — not even all the core area and its population."

He added: We seem to be getting the guy who is a casualty, but all the way at the bottom instead of intercepting it when he's still going down. And we're certainly not servicing the entire population — we're not getting to the people in the middle and upper socio-economic areas."

Patients from those areas are either treated with drugs through their family doctor or, "they enter the psychiatric system, again through contact with their own doctors," Mr Burdick said.

The other "signifigant revelation" in the survey, said the research director, is the number of revolving-door clients, people who require service many times in a row, is much smaller than originally suspectcd.

Mr Burdick said researchers were pleased with the amount of co-operation they received from the various agencies they examined.

The survey indicated it might be a good idea to create a residential anti-alcoholism facility outside Winnipeg which would take problem drinkers, who agree to the treatmcnt, out of city-circulation. Right now, clients are often — and in Mr Burdick's opinion quite properly — referred from agency to agency within Winnipeg.

He said if there was any fear on the part of agencies that the Alcoholism Foundation of Manitoba was increasingly assuming leadership and threatening autonomy, "this fear certainly was not evident".

Mr Burdick said several agencies had suggested a black-list file of names of patients should be compiled and the patients in that file should no longer be admitted to service because they had abused it.

However, the idea was quickly dispelled "because it was so clearly illegal and immoral, even though it might have been expedient for the agencies — it was just not right," said the research director.

Clean air: a non-smoker's right

By Betty Lou Lee

CHICAGO — Minnesota non-smokers have succeeded in getting a Clean Indoor Air Act passed to protect their rights and health against second-hand smoke,

Now they are engaged in a massive education and implementation program to ensure that it is enforced, particularly in offices and other work places where the carbon monoxide level can easily excced the threshold limit set by the Occupational Health and Safety Administration.

Barbara Anderson, managing director of the Ramsey County Lung association in St. Paul, outlined thc two-year battle to get the act at the annual meeting of the American Public Health Association.

Her association and its sister one in Minneapolis organized the Association for Non-Smokers Rights (ANSR) in February, 1973, with an executive committee of 10 community representatives. Each one headed a sub-committee that focused on a specific problem area such as hospitals, restaurants, legislation, publicity, or students.

"Opposition was at first monumental" as the committees started their awareness program for businesses and public facilities, Ms Anderson said.

"As ANSR became more dynamic and cohesive, public sentiment began to change favorably. A massive public relations and public education campaign turned the association into a progressive force within the health field."

The clean air bill was in a constant state of revision as it was guided through both houses of the state government by sympathetic legislators.

"The difficulty encountered in writing this type of health bill is the broad generalizations that must bc made in hopes of simplifying the wording," Ms Anderson said. "The specifics of what constitutes a public place became the essential focal point. Extreme caution was exercised as to what was included and excluded in the definition.

"Sponsors of the bill felt that any place that was nccessary to one's general existence should be covered by the term public place, and designated non-smoking and smoking areas should be available. Bars, privately-sponsored social functions, and offices occupied exclusively by smokers were excluded from the 'public place' terminology."

While the majority of complaints about non-smokers' rights the association received involved working situations, this proved to be one of the most controversial aspects of the bill.

It stipulated that the Minnesota Department of Labor and Industry and the Board of Health were responsiblc for establishing rules to restrict or prohibit smoking where close proximity of workers or inadequacy of ventilation causes smoke pollution detrimental to the health and comfort of non-smoking workers.

ANSR is now determined that the Minnesota act will not follow the fate of a similar one passed in Arizona which was "passed, forgotten and finally ignored".

It has made the provisions of the bill, written in laymen's terms, available to everyone in the state. Meetings have been held with all voluntary health agencies, the state board of health, Chambers of Commerce, health care facilities, and physicians, to acquaint them with the ramifications of the act. The emphasis is on positive health benefits, rather than on negative prohibition of smoking.

Noble: compassion with excellence, is a necessity

By Charles Marwick

ROCKVILLE MARYLAND — Dr Ernest P Noble takes over the directorship of the National Institute on Alcohol Abuse and Alcoholism (NIAAA) at a time when he sees "a sense of excitement" in the field of alcoholism".

There is now a clear national focus on the problems of alcoholism through the NIAAA, "an identifiable body through which most of the efforts in alcoholism are channeled", he says.

"I have come here with a sense of mission. I suggest that soon it will be possible to address ourselves meaningfully to the problem of alcohol and alcoholism. I intend to translate this to effective reality".

The problem of alcohol abuse and alcoholism cannot be studied completely by biomedical models", Dr Noble believes. "However we do need to do bench-type research", he says, and looks forward to expanding the focus of research activities at NIAAA.

"I would like to see psychobiological studies undertaken. I have some interest in blocking agents", he notes.

Dr Noble has published research studies indicating that there are mediators of alcoholic metabolism which might be harnessed in the clinical situation to inhibit the effects of alcohol.

The NIAAA's new director cites the in-house research programs run by the National Institute of Mental Health (NIH) as an example of the kind of research activities he is talking about.

"I would like to stimulate this type of research at NIAAA and work effectively with other agencies such as some of the institutes at the National Institutes of Health".

In the recent past, NIAAA has been criticized for not working closely with other government research programs such as those at NIMH and at the National Institute of Neurological Diseases. This, it is held, has resulted in unnecessary duplication.

Dr Noble recalls how his interest in alcoholism was first awakened.

"You know, as I look back now I can't think of a single lecture that I had as a medical student, whether in biochemistry, physiology, or pharmacology, that related to alcoholism.

"Yet, when I went on the wards as a clinical clerk I came across alcoholics. At that time they were viewed as objects of derision. To be sure we would occasionally take a liver biopsy to look as if we were tackling the case according to the precepts of acceptable medical practice.

"We diagnosed cirrhosis of the liver, esophageal varices, anemia, gastritis, what have you. We called them alcohol-associated problems. We never called them what they really were — alcoholism.

"Yet there was this poor human being with a big belly, bleeding from the mouth, all the medical problems of alcoholism. And we knew full well that two courses faced this patient. One was that he either died then and there in the hospital or that he got symptomatic relief, left the hospital, only to drink again and come back to die, sometime later. This sense of hopelessness coupled with disinterest, prevailed in the treatment of the alcoholic individual for many years.

"Then, in the later 1960's there began to develop a growing recognition of the true magnitude of the alcohol problem. With this development and with the growth of funds in the alcohol field, prestigious investigators were attracted. These were soon followed by young, vigorous and imaginative investigators. The result is that today it is becoming acceptable and respectable to conduct research in alcoholism. No longer do you hear people apologizing for working in the field. There is now a real momentum in the field of alcoholism. It's very exciting".

"You know", Dr Noble went on, "we talk on glibly about the facts. We say there are nine million alcoholics in the country. But is this the whole story? My hunch is that there's more, probably many more. We know that fully a hundred million Americans drink and we don't even talk about the problem this poses — for the most part anyway.

"We look only at the top of the iceberg. We don't know about the kinds of damage that occurs among people who drink alcohol in moderation. Yet we do know from our research that, even in limited amounts, alcohol can affect brain function. So I'm not sure that those whom we call alcoholics are the only ones who suffer from alcoholism.

"Certainly, we need to treat those who drink so much that their brains, their livers, their hearts, and other organs are affected. These are medical problems. But we also need to find out what these underlying problems are.

"What happens to a young boy or girl who takes his first drink? Is it his genetic constitution that determines the way he handles alcohol? Is it the metabolism? Is it the psychology? Is it the social environment that gets him to drink?

"We don't know the answers. I think that finding these answers is a research question and the sooner we find them, the better we can respond to such questions as: How do we prevent alcoholism?

Prevention is one of Dr Noble's principal goals. "I am not happy with what I see in terms of some of the prevention programs in existence at the moment", he says.

"I don't think that just labelling the bottle with a warning along the lines of the cigarette packet is going to change people's behavior. This is a very subtle area. We have to understand the crucial factors that underlie the drinking patterns. If we can understand these then maybe we can do something about modifying drinking behavior.

"I would like to bring to this field and to NIAAA a sense of excellence", said Dr Noble, "but excellence tempered with compassion. We are not dealing with just molecules, we are not dealing with just programs. We are dealing with people's lives".

Emotions muddy pot picture

MONTREAL, QUE. — Results of cannabis studies vary because investigators have been basing their conclusions on personal, moral standards.

This is the opinion of Dr John Unwin, a Montreal psychiatrist and acting director of the Royal York Hospital Methadone Maintenance Clinic.

"My own review of cannabis studies indicated they were poorly controlled — a finding later confirmed by others," Dr Unwin told participants in a recent symposium on psychological and ethical aspects of pediatric practice.

He referred to a recent report by Toronto psychiatrist, Dr Andrew Malcolm, which states cannabis is carcinogenic and lowers testosterone levels.

However, Dr Unwin emphasized, the US National Council on Drug Abuse has been unable to make any definite statements about the danger or safety of cannabis "at this time".

"Not only in investigators, but in people generally, there was an emotionalism that made them vehemently against cannabis use," Dr Unwin said.

The basic principle being challenged by marijuana users is the Puritan work ethic, according to Dr Unwin.

"(It's) an over-whelming fear that someone, somewhere, may be enjoying himself. This is exactly the reaction that occurred when we saw young people appearing to have a licentious, libidinous occasion with drugs," he said.

"There was something wrong with young people having pleasure and appearing to enjoy themselves. They hadn't worked in the fields, hadn't learned their arithmetic for hours . . . "

Dr Unwin encouraged a "holistic" approach to cannabis use — something that would allow for several standards — "because many who use cannabis do stick to the ethics with which they grew up".

Sudden death unrelated to smoking

ANAHEIM, CALIF. — Although cigarette smoking is a known risk factor for heart attacks, it does not appear to be related to an increase in the frequency of a type of premature heartbeat which is associated with sudden death.

"Ventricular premature contractions (VPCs)— the type of heartbeats which may be associated with sudden death — are no more frequent among men who are now smoking cigarettes than they are among men who formerly smoked, or who never smoked", Dr Lawrence E. Hinkle, professor of medicine at Cornell University, told a major session here of the annual American Heart Association convention.

"Observation of tape recordings made while men are smoking indicates the smoking of a cigarette by an habitual smoker is only rarely accompanied by an increase in the frequency of ventricular premature contractions.

Dr Hinkle said his conclusions were based on the study of 1,196 actively-employed American men, ranging in age from 20 to 65 years, who were considered to be at high risk of sudden death from a heart attack.

Each man had either six- or 24-hour electrocardiograms to determine the incidence of VPCs, since these contractions, in some cases, may be the forerunners of ventricular fibrillation and death.

Open Arms for women in Hamilton

HAMILTON — A $63,000 Local Initiatives Program grant has been awarded the Open Arms Haven for Women to establish the city's first halfway house for female alcoholics who are no longer drinking.

"It's for the woman who has stopped drinking but still needs some emotional support for her to function normally," says Open Arms director Marguerite O'Rourke.

The L.I.P. grant will cover the six-bed operation for seven months, and Mrs. O'Rourke hopes the community will then finance the project.

"There's such a need. The government recognizes this as well as we do. There's no other place for women to go".

Twelve Open Arms employees will get on-the-job training in self-help courses for the women. Course topics will include how to relax and cope with everyday problems, with health, nutrition, dress, and alcohol and its effects on the body.

Children must be taught to drink—safely

TOLEDO, OHIO — An important part of alcohol education for the young should be the differentiation of reasons for drinking, says Dr Martin G. Wolfish, associate professor of pediatrics at the University of Toronto.

"We must point out that drinking for curiosity, peer acceptance, or conviviality is not the same as drinking alone, drinking to get drunk, or drinking to take our cares away," Dr Wolfish told physicians at a continuing education course at the Medical College of Ohio, Toledo.

He cited a Toronto study of 13-year-olds that showed 5% had got drunk, not by accident, "but to relieve loneliness, to forget problems and for other clearly definable reasons not related to curiosity, peer acceptance or peer pressure, but for relief of unhappy emotional states".

This study of 100 13-year-olds, done at the Hospital for Sick Children in 1973, found 75% of them had drunk alcohol outside their homes, and 10% admitted to being intoxicated at some time.

This did not include table wines taken with meals at home, Sabbath wine, a sip of a parent's drink, or other parentally-supervised drinking within the home.

Much of our teaching concerning alcohol is prohibitionary in origin and content, and may be irrelevant to today's standards where 68% of all adults drink, Dr Wolfish said. "Peer influence is most important and children must be taught responsible drinking habits.

"It is important to tell children that is not essential to drink, that getting drunk does not indicate maturity, virility or masculinity.

"We must teach our children to drink safely. We must explain physiological facts to them. They should be taught about drinking slowly, drinking and eating together, and other factors that some of us have learned by experience.

Alcohol education should probably not be dealt with as an isolated topic, but should be part of the understanding of living and coping with life's problems by teenagers."

Dr Wolfish is also chief of pediatrics at North York General Hospital, Willowdale, Ont.

With a certification prototype

Nevada forges ahead

By Milan Korcok

CARSON CITY, NEV. — Ask anyone who's ever been to Las Vegas or Reno and they'll tell you straight out..

"Nevada is "something else".

And even if all they're reacting to is the wheel, the table, or the one-armed bandit, they've got a good point.

But Nevada is different in other respects too.

There's no recession here. Money, most of it from out of state, flows freely. For the first time in its history, Nevada, in 1974, grossed $1 billion in gambling, and the first three quarters of 1975 showed gaming revenues surging far ahead of those previous record levels.

Short term pleasure is the state's greatest natural resource, but the fallout — alcohol and drug abuse — doesn't dissipate when the tourists leave.

Fortunately, the political and social leaders of this sparsely-populated state don't have too much of an inferiority complex. In tackling the growing problem of alcohol and drug abuse, they see no need to sit around and take their cues from other, wealthier, more powerful jurisdictions.

The result is that the state has charged ahead with an innovative model for certifying, accrediting, and licensing alcohol and drug treatment facilities and personnel that deserves scrutiny throughout this continent.

As Paul Cohen, Chief of the State's Bureau of Alcohol and Drug Abuse (BADA) says: "We looked around at other states, and there was no place to go. Nevada couldn't wait. We would have to invent the wheel."

Accreditation of drug and alcohol treatment programs, and certification of the people who work in these programs as counsellors, has been an elusive process throughout North America. The definition of minimal standards that would work in all jurisdictions is still a pipe dream to those who talk in terms of national criteria, or national training systems.

But with a population of only 600,000, a budget of close to $3 million, and a recently-established State Plan for Prevention, Treatment and Rehabilitation of Substance Abuse, Nevada's BADA had a lot going for it.

For some time there has been a lot of concern about setting some kinds of standards for alcohol and drug counselling professionals. Patricia Bates, Statewide Program Coordinator for BADA was mincing no words when she said: "It was clear the time had come when the service being provided by the counsellors who had taken such great efforts to educate themselves would have to be recognized.

"College degrees and experience do not a counsellor make," reiterates Ms Bates, herself a non-academic, albeit one who has taught counselling at numerous courses in universities around the country.

Fundamental to BADA's quality control strategy was the conviction that approaching certification of counsellors as an item apart from the accreditation of programs or the licensure of facilities just didn't make sense.

Consequently, when the state passed a series of bills governing the regulation of alcohol and drug abuse treatment in 1975, they neatly dovetailed certification, accreditation, and licensing, and gave their criteria for each the force of law.

From the start, Mr Cohen and his colleagues in BADA knew they would have to tred delicately in defining the criteria for certification of counsellors.

A survey in 1974 showed that more than six out of every 10 counsellors in drug and alcohol treatment programs in the state were non-degreed paraprofessionals.

Rather than academic traning, they had according to Mr Cohen, "a heart as big as the state of Nevada and a desire to reach out and help".

"Whatever we did, we would have to develop some mechanisms that would not wipe these people out. A lot of paranoia existed.

"Considering the high proportion of counsellors who were non-degreed, we knew that if we developed any kind of academic test, many of them would fall flat on their faces.

"When that kind of person fails a test what do we tell him? How can we negate the fact that he's been working in a program for five years doing one hell of a good job?"

The point is, you don't deny the fact you give him credit for it. But if criteria are to be of any value they have to define a line.

This is how Nevada's certification procedure defines that line.

There are four distinct categories under which an individual might be certified. A person may opt for one, or a combination of more:

- Drug Abuse Counsellor,
- Alcohol Abuse Counsellor
- Substance Abuse Counsellor (for those programs where treatment involves multiple drug users), or a
- Program Administrator.

The requirements for certification call for the following:

- A graduate degree in an appropriate social science field,
- A bachelor's degree plus two years of life experience, and
- a number of years of life experience plus successful ecompletion of a provisional certificate.

(Full certification consists of a six year credential. Any counsellor not measuring up to all the criteria can be granted a provisional three-year certificate during which he takes on the training required to fill in the gaps revealed by the certification board.)

This provisional certificate was BADA's alternative to a grandfather clause which would allow those who failed the exams to stay on in their jobs by virtue of the fact they were already in the business.

In addition, the candiate also has to satisfy the certification board that he has not abused any controlled substance within the previous two years, has been a state resident for six months, and has the ability to communicate effectively.

The counsellor must be able to recognize symptoms, assess a client, evaluate his progress and set realistic goals. He must be capable of involving himself with the addict's family, and be able to develop a professional counsellor-patient relationship.

He must have knowledge of group counselling methods, of what motivates and elicits feelings, and what constitutes a continuum of care. He must be aware of basic medical requirements, the problems accompanying sobriety, the steps and traditions of Alcoholics Anonymous.

In essence, the power to certify candidates is given to BADA by legislation, but in fact this responsibility is given over to a Board of Certification made up of people active in the field of drug abuse and training. Right now it consists of one substance abuse counsellor, one alcoholism counsellor, one licensed psychologist, one educator, and one BADA representative. The board was selected from a slate of nominees recommended by the programs themselves.

The Board's powers are broad. It might waive an oral examination if the candidate passes the written one, and it has a lot of influence in directing the candidate into a training programs to correct certain deficiencies.

One of the beauties of living in a small state (small in terms of population only) is that flexibility is just a phone call away.

Mr Cohen prides himself (or rather the establishment he represents) on the ability to put together a training program (paid for the state) for a specific counsellor or group of counsellors in short order.

"Let's say a counsellor has a deficiency in basic information intake. He just doesn't know how to get information from a client. We set up a training course for him. We can run a training course within 21 days of finding the need. We can pull in somebody, somewhere in the state.

"We've run a course for six people who could only communicate in Spanish," says Mr Cohen.

In discussions about credentialling held throughout the country, the fact that it should be a voluntary process is always front and centre.

Though Nevada's program is characterized as voluntary, no amount of hair-splitting can obscure the fact that anyone who wants to continue to work for state or federally funded programs, must get certified.

One wonders if it could work any other way.

Nevada's legislation is precise: In order to be licensed, any facility receiving state or federal funds must be accredited. The program accreditation powers given BADA are just as precise and tight as are those for counsellor certification.

In order for a program to be accredited (i.e. licensed) "All counselling staff SHALL be certified by the Bureau of Alcohol and Drug Abuse." And if individuals are not holders of a full certificate they must have at least a provisional three-year one.

There are options, says Mr Cohen. If some programs or individuals don't want to go through the certification process they don't have to. They can just give up any claim to state or federal funds.

Since the licensing process has just been initiated, BADA is giving candidates some leeway. In effect, they or their program administrators have until mid or late 1976 either to go through the certification process or declare a time line as to when they will go through.

There comes a time when we must either "fish or cut bait," says Mr. Cohen.

By the time the first deadline for filing to sit certification came up in late November, close to 125 applicants had shown up . . . some of these from people outside the circumscribed drug field.

Of applicants, approximately 60% were degreed and 40% non-degreed.

Within a week after that deadline another 22 applied for the subsequent set of examinations.

Mr Cohen was elated at the turnout, optimistic about the numbers of non-degreed workers who took the bait at the first pass.

The first set of examinations is being held in early January, subsequent series will be held a couple of months later. After that, it is expected that examinations will be held twice a year.

By the end of 1975, close to 50% of all the drug and alcohol abuse workers functioning as counsellors had come in for the certification process.

The fact that his state may have developed a prototype for others doesn't displease Mr Cohen either.

"I'd love to have the reputation that other states were adopting our minimal standards as their minimal standards. I would love to have them develop this program for themselves. . . take our cover off and put their cover on."

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A diversion we can't afford

THERE IS something grossly misleading about the way public figures have taken off after young people and their drinking habits — young people being those between ages 18 and 21.

In the province of Ontario in 1971, when the legislature was lowering the drinking age to 18, scarcely a voice could be heard calling for caution in extending the right to drink to teenagers.

It should be recalled that this change was part of a trend towards defining the age of majority as 18 and, as such, was one of 37 statutes changed at the same time.

It is probably also true that young people were given drinking rights as a vote-catching technique. Certainly all three Ontario parties heartily endorsed the move and a provincial election did follow a few months later.

Most elected officials and even informed observers seemed to justify their actions by pointing out that the provision of alcohol to 18-, 19- and 20-year-olds simply recognized the reality that these age groups were drinking anyway.

Now, prodded by news reports that teenage drinking is on the rise, the bandwagon has been pulled out of mothballs and everyone who gets a chance at a microphone is suddenly "viewing with alarm".

Yes, there is evidence that people between the ages of 18 and 21 are drinking more today than they did before the age of majority was lowered. And yes, there is evidence that more young people are getting into trouble with auto accidents and other health problems as a consequence of drinking.

But there is also evidence, and a lot more of it, that alcohol abuse in the past decade has escalated in the 21- to 35- to 78-year-old age groups, or any other age group you want to mention.

Surely, increased drinking by young people should come as no surprise at a time when per capita drinking in Ontario has reached a peak. In fact, per capita consumption rose 28% between 1963 and 1973 and it would appear the percentage of Canadians beyond 18 who drink has probably reached its maximum level of approximately 90%.

In effect, North American society is on a binge: how can we expect the 18-, 19- or 20-year-old to stand on the sidelines?

To a certain extent, young people, those between 18 and 21 years, are being made scapegoats because they are an easily definable group.

"Adults" are quite accustomed to preaching to this group anyway, and they see it as part of their parental obligations. So the finger-wagging comes quite naturally.

In retrospect, the decision to lower the drinking age in jurisidictions throughout North America, was a questionable one. Returning the proscription to 19 or 21 may be the right action now, even if it causes political and social leaders to eat a certain amount of crow.

But, and it's a big but, if we unload all our legislative resources upon young people and make examples of them, and only them, we simply succeed in going two steps forward and two steps back. We don't need any of these diversions pulling us off the track.

Any efforts to reverse the present trend of teenage drinking must be considered against overall attempts of Canadian society both to alter attitudes towards the use of alcohol and to apply effective control measures, the end objective being to prevent further increases in consumption and resulting alcohol problems.

If we are truly concerned about our young people as well as ourselves, we will create a climate in which drinking alcohol to excess is not seen as a function of good citizenship and eliminate the hypocrisy that proscribes alcohol for one segment of the population while the majority continues to consume at prodigious rates.

The double standard in respect to drug use has caused enough social upheaval already.

There are *real* ways we can confront the problem of alcohol abuse. There are actions legislators can take if they have the courage.

Raising the legal drinking age, allowing roadside breathalyzers, applying stricter enforcement methods can be part of that initiative, but only a part.

We have recourse to many other potentially effective mechanisms of control — pricing and taxation policies, advertising and promotion restrictions, tighter regulation of licensing of facilities and distribution of alcohol.

These are the devices which can influence the rate at which everybody drinks. That's what we really ought to be concerned about and what we ought to be talking about.

Letters to the Editor

More letters — page 11

Jail drinking drivers

Sir:

The following is a copy of a letter which I have sent to the Attorney-General of Ontario:

I am a Bar Admission student who, as a former social worker, has had employment experience as a parole officer and a counsellor in various prison settings. I was most interested in your statements concerning stiffer penalties for drinking drivers and jail sentences for first offenders.

I am in full agreement with you regarding the need to have stiffer penalties for drinking drivers and automatic jail sentences for first offenders. While in prison, these individuals should be required to undergo intensive counselling sessions. These sessions would include visits to the morgue and viewing films of accident victims. Finally, once a sentence had expired, an individual who was identified as an alcoholic or near alcoholic would be required to submit to compulsory therapy as a condition of having licence privileges renewed. If the individual did not demonstrate much motivation for change in the therapy sessions, the licence privileges should never be renewed. After all, a privilege is not a right.

As penalties for subsequent offences, I would suggest suspension of licence privileges for life, impoundment of the vehicle (to be followed by a judicial sale with the proceeds reverting to the provincial treasurer) and further imprisonment.

Finally, I would submit that the police should be instructed to enforce the law against any individual, even if that individual be a judge, cabinet minister, business executive, etc. I understand that this is the policy in one of the Scandinavian countries and it is designed to shock even those individuals to realize the seriousness of their offences. It also serves as a deterrent to others. In that particular country, individuals from all social classes are required to spend the night in detoxification centres, and no distinction is made among social classes in enforcing the law as it pertains to drinking drivers.

Although some naive individuals would consider my proposals to be Draconian, it is my belief that we must have laws which will protect the public and rehabilitate those who need help. Hopefully, such an approach would reduce the butchery on the highways and eliminate needless pain and suffering. Although it would be politically unpopular to implement such a policy, I hope that you will have the courage to do so, and I hope that Stephen Lewis and Robert Nixon will have the courage to support such legislation.

Paul Gavrel
Toronto

Doctors' practices

Sir:

The last two issues of **The Journal** (November and December, 1975) have featured articles describing recent meetings on the subject of Women, Alcohol and Drugs. Both meetings, one US and one Canadian, reported similar findings regarding prescribed psychotropic drugs.

Dr Robert DuPont reports (December, page 5) from a US study that twice as many women as men have used diazepam and chlordiazepoxide (Valium and Librium); that 50% more women than men report the use of barbiturates for medicinal purposes, etc. He also reports that the percentage of women who use 'pills' to cope with stress has increased 30% from 1972 to 1974 with no similar increase among males.

On the same page as the above is an interview with Dr DuPont in which he points out that, given the same symptoms, physicians do not discriminate in their prescribing to the two sexes. This article is headed, "MD's Prescription Habits Similar for Both Sexes".

Within the context of the statement on symptom presentation, this appears a reasonable headline but for the reader who skims **The Journal** lightly, it nonetheless suggests there is little wrong with US or Canadian physicians' prescribing practices. One has to read much further along in the article to find Dr DuPont's statement that: "This is not to argue that all prescribing of psychoactive drugs is necessary or appropriate."

The implication of the headline, however, is that little is wrong with current prescribing if no overt bias exists.

(continued on page 11)

Backgrounder

By Milan Korcok

Certification of alcohol or drug abuse counsellors is a high priority item among people involved in treatment today. In a series of backgrounders, Milan Korcok, contributing editor of **The Journal**, *looks at the pros and cons of credentialling, the fears of some counsellors about the future, and some of the practical problems involved in developing national training systems.*

COUNSELLING the alcholic or the drug addict is a very imprecise art, requiring an eclectic blend of qualities.

Over the years, such counselling has been monopolized by the street-wise addict, the individual who knew where it was all coming from, and whose experience and intuition made up for any perceived lack of scholastic training.

But with the growing sophistication of drug treatment programming, and the involvement of academically-trained "professionals", the complexion of counselling has changed. It has become more structured.

Counselling has become "A New Profession", open for scrutiny not only by alcohol and drug programmers, but by the various regulatory and funding agencies at state, federal, and provincial levels.

Clearly, if programs are to receive public funding they must become accountable. They have to ensure their paymaster that services provided are of an acceptable standard, that their facilities and personnel meet certain criteria, that there is some uniformity in services from one community to another.

As part of this quest for accountability, there has been emphasis recently on development of quality control mechanisms such as certification of individual workers, and accreditation of drug and alcohol treatment programs — both of which are usually voluntary processes not to be confused with mandatory licensing procedures implemented by state or provincial regulatory agencies.

Certification reflects the attainment, by an individual counsellor, of credentials stating he has the competencies required to conduct certain counselling activities. It is not a licence to practice.

That is simple enough in theory, but national groups in both Canada and the United States are finding the issue of credentialling of counsellors anything but simple and straight forward.

In Canada, a federal-provincial task force on training of counsellors for alcohol and drug services, made up of representatives from the provinces, territories, and the federal Non-Medical Use of Drugs Directorate, has been wrestling with the concept of developing a national training system for counsellors.

The task force has been seeking to identify the target groups most in need of training and looking at their educational needs. In the course of this scrutiny it has run into a complex mass of issues.

Should all counsellors be forced to meet the same minimum standards of competency? If so, how can you define the standards? What kind of educational process might be developed to ensure that they meet these standards? How do you account for the great regional differences both in terms of need and available personnel, i.e., the alcohol counsellor dealing with native people in the Yukon doesn't necessarily need the same kinds of skills as a counsellor in Montreal's skid row . . . or does he?

In the United States, the NIAAA commissioned Roy Littlejohn Associates to develop proposals for a national standard for alcoholism counsellors, and NIDA asked for an analogous project as it affects drug programs to be prepared by the University Research Corporation.

The details of the reports have been discussed in detail by various groups, but the questions these reports and task forces have raised so far make it obvious that a national training system — if one is required — is a long way off.

Some jurisdictions, British Columbia, and Nevada have in the absence of any national consensus, surged ahead on their own in developing certification processes for counsellors.

Though alcohol and drug treatment and rehabilitation has gradually fused into the health delivery systems of the United States and Canada, the deliverers of those services have not emerged with a clearly distinct identity, the way other health workers have.

In one state or province a counsellor may require a master's degree to work, in another the counsellor may need no degree at all. The inequities are blatant.

At the same time, a counsellor may work hard to receive a certificate from a training institution in one jurisdiction only to find the piece of paper worthless in another. Professional mobility is something that just doesn't exist among counsellors the way it does in other health fields.

Keenly aware of this lack of vertical or horizontal mobility, the Alcohol and Drug Problems Association of North America launched its own national initiative to establish credentialling processes for counsellors.

Though ADPA, in the words of its President H. Leonard Boche, does not intend to become the body doing the certification, it does seek to act as an expediter to see some process takes shape.

Says Mr Boche: "We can no longer sit around and contemplate and weave the perfect system."

In surveying the various initiatives now going into the credentialling of counsellors, the Drug Abuse Council has nicely put its finger on some of the key issues.

The study, headed up by DAC Project Officer Carl Akins (Akins is now with the Illinois Dangerous Drugs and Narcotics Commission), notes that if credentialling is going to do more good than harm, it will have to be "as open as possible so that the basic reason for credentialling — to improve the quality of services — does not get submerged by bureaucratic, economic, or selfish considerations as has happened with credentialling efforts in other fields."

Implicit in this concern is the fear that if credentialling becomes too rigid, too bureaucratized and structured, its first victims will be the many non-degreed, non academically-trained people who have been the foundation of counselling in North America.

The DAC comes down hard on the need for retaining competency as the chief criterion for certification.

"Credentialling in substance abuse does not depend on the possession of any other sorts of credentials whether they be academic degrees, medical licences, or other sorts of certificates."

There is an urgency to developing standards and there are fears that attend that urgency.

As the DAC survey says: "The funding of drug programs is being reduced, and thus there is a need to devise some systematic method of evaluating the services."

There is also some anxiety about the imminence of third party health insurance.

What kinds of programs will third party payers cover? What criteria will programs have to meet in order to qualify for coverage? Will a credential of some kind not be required by the paying agency before an individual counsellors services would be reimbursable?

The State of Nevada (See page 7), has forged ahead on its own, developing legislative authority for licensing of programs as well as credentialling of individual counsellors. It has etched in law the condition that treatment programs will lose their federal or state funding unless their counsellors take advantage of the evolving credentialling process to get their certificate of competence, or at least a provisional certificate showing them to be in training. They have been given until late 1976 to comply.

Is this to be the prototype for other states?

The prospect of credentialling, as ill defined as it is today, has uncovered some deep anxieties among many workers today.

Who is to be credentialled? Who is to do it? What skills will be included and how will they be measured? What credit will be given for life experience and how will this stack up compared to academic training?

They are afraid of other things:

- That credentialling will be used as a tool to weed out "paraprofessionals."
- That rigid codification of the credentialling process will favor the medical model in treatment facilities.
- That programs serving poor and ethnic minorities would suffer most since these are most dependent upon paraprofessionals for counselling services.

The need for protecting the many, existing, non-academic, non-degreed counsellors is crucial to credentialling.

Though weight may be given to life experience, written or oral examinations of some kind appear inevitable. Some codification of required skills will have to be measured.

Will today's non-degreed counsellors be herded into community colleges, will the quest for diplomas become their promary concern?

The prospect to many is disconcerting. The need to prove oneself against academic criteria is distasteful to many.

There is an art to passing examinations. The BA student has been carefully tutored in that art, the non-addict counsellor has not.

'Then felt I like some watcher of the skies
When a new planet swims into his ken'

By Wayne Howell

SO SAID John Keats, upon first looking into Chapman's famous translation of Homer. Now I cannot say I had exactly the same feeling upon first looking into a copy of *High Times*, the New York-based glossy magazine dedicated to the pleasures of pot and the comforts of coke. But it did, in a figurative sense, blow my mind:

Imagine if you will, a counter-culture magazine that looks as if it were designed by the people who publish *Psychology Today* — slick graphics, quality paper, good layout — and carries a style of advertisement similar to those in *Harpers* or *Macleans*. I say a 'style' of advertisement, because although one is used to full-color back-cover ads for cigarettes in glossy mags, one is not used to full-color back-cover ads just for the cigarette paper!

Like *Playboy*, every issue of *High Times* carries an exclusive interview up front. The September issue, for instance, features an interview with a Harvard-doctor-cum-freak who offers the theory that vomiting may be an interesting high. According to the doctor, food layers up in your stomach like a parfait within 20 minutes of eating, and you can throw it up layers at a time, establishing a bridge between the unconscious sphere and the conscious sphere which produces a flow of energy which is a unique feeling. Barf is bliss, in other words.

The spring '75 issue features an interview with a professional marijuana taster. This James Beard of the cannabis crowd prowls the mountains of Mexico and Central America looking for greatness like a pro hockey scout prowls the boondocks of Northern Ontario. A true epicure, his decisions and recommendations can affect the price by up to $30 or $40 a pound.

When it comes to things like prices, one must turn to the 'business' section or the 'Trans-High Market Quotations' which list the prices of psychoactive substances around the world the way the *Wall Street Journal* lists the price of less esoteric commodities. Along with Amsterdam, Katmandu, and Marrakesh, Montreal gets a listing. Toronto doesn't — which proves, I suppose, that it takes more than just a fancy communications tower to make a true 'international' city.

To keep up with new products, *High Times* offers a 'Paraphernalia' section in which new products are featured and compared Consumers' Report fashion. The October issue gives a rundown on three marijuana cleaners, a product named The Clean Machine getting the nod over the 'Juana Shaker and the Marygin because it is made of durable metal and can even double as a flour sifter. The Tooter is recommended as just the thing for people too busy to inhale their own cocaine. It comes in black, silver, and industrial blue and is a little mechanical device that delivers scientifically accurate snorts of coke up your nostril at the press of a button. It comes for only $25 and is, I imagine, guaranteed for the life of your nasal septum.

The advertisements in *High Times* are a tribute to good old American know-how and inventiveness. There is a bewildering variety of pipes and hookahs offered for sale — each one with its own special engineering and features, such as the 'Waterbong' that 'cools like a hookah', has a vast carburation chamber for those 'fast working mighty hits', and is 'dishwasher safe' as well!

Those mundane toilers of the industry — the dealers — are not neglected by *High Times*. A full page ad for 'd-ometers' suggests: "When it's one of those days you can't trust your head, you

(continued on page 11)

Turkish poppy plan: experts optimistic

By Thomas Land

GENEVA — Within the next two months, narcotics specialists of the Western World will be able to assess with confidence the effects on the illicit markets of the resumption of opium poppy cultivation in Turkey.

Officials at the United Nations' International Narcotics Control Board in Geneva are optimistic. It appears a unique system of control imposed on poppy farmers in the seven Turkish provinces where legal cultivation was resumed last year, after a short-lived total ban, has managed to prevent trafficking.

But specialists emphasize, if the alkaloids from the country's increasing poppy crops are to be used solely to supply the pharmaceutical industry, Turkey must be given "substantial" financial assistance for investment in storage and processing facilities.

Turkey has been traditionally, the major source of illegal heroin supply finding its way to the rich and desperate markets of Canada, the United States and Western Europe. Both the Turkish authorities and the 11-member UN board responsible for supervising compliance with international conventions, believe the illegal supplies still trickling out of the country are leftovers of stocks accumulated before the 1971 ban on production.

Advanced studies have already been made under international auspices of the financial requirements of Turkey's developing opium poppy industry. No figures have yet been named.

A specialist spokesman for the UN board explains that "the use of poppy straw for the extraction of alkaloids presents many advantages because it is more difficult to use for illicit purposes than opium. Furthermore, in order to obtain sufficient quantities of morphine, the traffickers would have to secure very large amounts of straw through clandestine channels.

"As the capsules are no longer lanced, poppy can be cultivated more densely, producing a greater quantity of capsules per hectare. In addition, the morphine yield will be higher and the quantity of poppy seeds, traditionally used for food and oil production, will be increased."

But the transportation, storage and processing of poppy straw is an expensive business. UN officials emphasize that "the construction of industrial facilities for the processing of that raw material requires substantial capital investment.

"Turkey has already requested, and received, multilateral assistance for the study of some of these problems. It will require more substantial aid. The international community will certainly wish to help Turkey to pursue a policy in whose success it is so vitally and directly interested."

The satirical Soviet weekly **Krokodil** *recently published a cartoon of a drug pusher wielding a fanatasy-sized hypodermic needle against a frightened teenager. The caption, 'Your money and your life' is a warning to the Soviets that drug use in that country is becoming increasingly frequent.*

Crime, violence, accidents

Soviets blame alcohol

By John Dornberg

MUNICH — Additional and unusually detailed statistics on the alcohol problem in the Soviet Union have become available to Sovietologists here.

According to the most recent (October) issue of *Molodoi Kommunist*, the monthly Komsomol, the Young Communist League, 8% of all non-accidental deaths in the USSR are due to extreme intoxication or can otherwise be traced to alcohol abuse.

Drunkenness was a causative factor in 55% of all fatal industrial accidents, and inebriation at the wheel was responsible for one-third of all the USSR's traffic fatalities last year.

According to *Molodoi Kommunist*, 53.3% of all crimes in the USSR are committed under the influence of alcohol and inebriation played the major contributory role in 73.9% of all murders and 76.4% of the rapes committed in the USSR.

The magazine also reported that 70% to 95% of all school-age children — the proportion varies according to ethnic groups and republics within the Soviet Union — consume alcoholic beverages "regularly."

According to the magazine, the average Soviet family spends 6.7% of its monthly budget on alcohol beverages. This figure, however, is contradicted by a little-known booklet on the Soviet economy which has recently reached Western analysts.

According to the booklet, *Proizvodtsvo i Uroven Zhizni Naroda*, (National Production and Standard of Living, published in 1973 by L. Kuprienko and E. Rusanov), the proportion spent on alcoholic beverages is considerably greater.

The authors analyzed the monthly spending patterns of both urban blue and white collar families as well as rural *kolkhoz* (collective farm) families, dividing them into "lower" and "higher" income categories, that is those earning less than 189 rubles ($251) and those earning 277 rubles ($368) a month or more.

In the lower income urban families an average of 9.57% of the budget is spent on alcohol; in the higher income families 14.6% of the budget goes for alcoholic beverages.

The lower income group spends 45.7% of its budget for all food and drink, and the higher income group only for alcohol ranges from 21% to 43%.

Among rural *kolkhoz* families the proportion of the total monthly family budget spent on alcohol is considerably lower. Those in the lower income category spend 7.3% those in the higher category 7.8%.

Observers here stress that the lower amount spent by rural families should not be construed as a reflection on their drinking patterns because illegal distilling and production of *samogon* (moonshine) are widespread in the Soviet countryside.

From the study of various Soviet statistical reports, analysts here estimate that almost one-third of the total spent annually for food and drink in the USSR — 96.5 billion rubles ($128.3 billion) in 1973 — goes for alcoholic beverages.

Alcohol is believed to come under the heading of "Other Food Products" in the Soviet Statistical Yearbook and in 1973 this category listed a retail turnover of 31 billion rubles ($41.2 billion).

The retail price of a half-liter bottle of vodka is 4.12 rubles ($5.48).

Tar yield down, smoking up

LONDON — The average tar yield of cigarettes consumed in Britain is on the decline, but this may only mean that nicotine addicts smoke more.

Behavioural research conducted at three British hospitals suggests it is possible to reduce the tar intake of smokers who cannot kick the habit provided the nicotine level of the tobacco is artificially maintained.

"It is up to the legislators and the cigarette manufacturers to decide whether this is a sensible objective for the habitual smoker," comments the authoritative weekly New Scientist of London.

Important new research findings on smokers, from studies at Maudsley, New Cross, and St. Bartholomew's hospitals, have been published here after a jubilant announcement by the Department of Health showing that the average tar yields of cigarettes on sale in this country have been reduced by about a tenth since testing began three years ago. A major objective in the department's campaign in publishing the tar yield tables has been to persuade people unable to break the habit "to change to milder blends with lower tar and nicotine yields".

One influential British daily newspaper describes smoking as "Britain's king-size tragedy" now claiming 50,000 lives annually and gaining ground among the young and particularly among young women.

A recent Gallup poll shows that, although 40% of people beyond 16 years smoke, and 65% of these think that smoking can damage their health, another 30% do not believe that cigarettes can kill them and 13% don't know. These figures, comments one specialist here, illustrate the failure of a comprehensive report produced by the Royal College of Physicians in 1971 and conclusively linking cancer deaths with smoking, to penetrate the awareness of the public.

Around t

LIGHTING UP

Chinese Vice-Premier Teng Hsaio-ping has rated people according to their smoking habits. "I suppose people who don't smoke at all are the best people in the world; those people who smoke pipes are the second best; and those who smoke cigarettes are the worst people in the world". Ping was speaking to pipe-smoking US President Gerald Ford and Secretary of State Henry Kissinger, who hasn't developed the habit. Teng incidentally, is a chain-smoker.

PERSONAL DRUGS 'OKAY'

A bill now going through Parliament in Italy is expected to remove the threat of a two-year jail term for smoking hashish. It will also allow Italians to keep small quantities of any drugs, including heroin and LSD, for personal use. However, it will still be a crime to buy, receive, import, transport or grow the drugs. Critics of the bill don't understand how one can possess drugs without first having bought or received them.

TONS OF BREW

Sixteen thousand million gallons of beer — that's how much beer was consumed in the world in 1973, according to statistics of the Brewing Review. US drinkers topped the beer-drinking market with 3,531,308,000 gallons consumed. West Germany came second with 1,999,800,000 gallons with Britons, having consumed 1,377,977 gallons, a close third.

Latin Americans map out program

CUERNAVACA, MEXICO — Scientists in Latin America are planning an information, research and educational network relating to drug abuse.

Participants from 14 countries recommended implementation of the network at the recent second conference of the Latin American Workshop for Research Programs on Drug Use.

Countries involved in the preliminary discussions were: Argentina; Brazil; Colombia; Costa Rica; Ecuador, Mexico; Nicaragua; Panama; Paraguay; Peru; Puerto Rico; Dominican Republic; Uruguay and Venezuela.

Recommendations include information exchange among the countries; publication of reports pertaining to drug use; a public education program; expanded training of personnel to be involved in the program; and a comparison study of present and planned rehabilitation programs.

A pilot project, to be initiated in Puerto Rico under the supervision of the island's Department of Services Against Addiction, will focus on programs now operating there, workshop participants decided.

A third conference is being planned.

'There's more than a hint of paranoia in HIGH TIMES'

(Continued from page 9)

need a d-ometer quality Tester as your friend'. All one need do is insert a small sample, (use the DM d-ometer for marijuana, hashish and THC, the DC d-ometer for cocaine) squeeze, and then match the color formed to the color quality chart. Simple as checking your own urine for glucose.

Several varieties of scales are offered and in the Spring '75 issue there is even a feature article on the latest in scales which recommends scales costing up to $1,200. Quite a bit of money — but then I imagine that to a dealer this would be a tax-deductible item.

High Times even offers a centre-fold to turn on the reader; the spring '75 issue has a sexy shot of some Thai grass posed with a pipe, and the August '75 issue offers a slightly risque look at some red Lebanese hash oil. Top that Bob Guccoine!

As one reads *High Times*, one cannot help making a few sociological observations:

The drug Quaalude appears to have achieved some sort of legendary status and is now sold as a cultural artifact. Enlarged gold and silver facsimiles of the tablet are offered as paperweights and pendants on delicate chains. Yesterday a downer, today an objet d'art.

There is a naivety in *High Times* that is almost touching. Fail-safe stash-holders such as 'the unique magic bean stash jar', 'the stash belt buckle', and the 'super stash', a three-inch long aluminum bolt that 'virtually defies detection' are offered for sale.

My God — if I can buy *High Times* surely the narcs can buy it too. I wouldn't recommend flying into JFK from Bogota with a pocket full of three inch long aluminum bolts!

There is a certain zany humour and frantic energy — especially in the ads — that makes it difficult for one to dislike *High Times* Yet one cannot help but feel it is a sad commentary on our times that this magazine, which has gone from a circulation of 20,000 to 250,000 in the course of a single year, has become such a commercial success.

Some of the feature articles in *High Times* are so incredible, so patently fabricated, that one wonders if this is not prima facie evidence that pot does indeed rot the mind. Certainly one would have to have a few neurons missing to accept such things as the interview with the professional taster or the fantastically elaborate market quotations as anything but the whimsical imaginings of a *High Times* editor.

There is more than a hint of paranoia in *High Times*. Many ads — some of them full page — offer security and anti-bugging services. These I imagine would be of greatest interest to dealers and the companies offering the services, such as Counter Measure Security Systems of Ann Arbor Michigan, appear to be the same companies that offer security services to business and industry.

Also, one gets the feeling there are a few rocks the editors of *High Times* want to leave unturned. In the Trans-High Market quotations, prices for opium are occasionally quoted, but never for heroin. I doubt very much if junkies are reading *High Times*.

Wayne Howell is an Ottawa physician and freelance writer.

e World

HEADACHE STUDY

The first survey of migraine among English school children shows that 13% of the 2,000 who took part suffer from it. The previous estimate, based on an earlier Swedish study, was about 4%. Only about 20% of the sufferers had told their teachers.

GERMAN WINE

Britain may be on the verge of outstripping even the United States in its consumption of German wine. Sales in the UK doubled between 1971 and 1973 and now stand at 200 million bottles a year.

FRENCH TOLL

Alcoholism kills nearly 22,000 people yearly in France, says a report by a government group. It shows France has the highest number of liver cirrhosis cases in the world and the average person drinks 141.8 litres (31 gallons) of wine every year.

UK POLL

Government interference in the sale of cigarettes and tobacco has considerable public support in the United Kingdom, according to a recent television opinion poll. Although 59% of the sample were against government control, 78% favored more curbs of one sort or another. Women were more insistent with 83% opting in favor of restrictions as against 72% of men. Of smokers, 69% accepted the idea of further restrictions.

More Letters ...

Continued from Page 8

We are in total agreement with Dr DuPont that physicians do not "push women, particularly, into drug use". May we suggest, however, based on the current state of our knowledge, that without conscious bias on the part of physicians, men, and particularly women, are being *eased* into psychotropic drug use by the increased acceptance of pharmacological solutions to social and personal problems.

Ruth Cooperstock
Scientist
Addiction Research Foundation of Ontario
33 Russell St., Toronto

SIR:

I am sure that someone would conclude I am an anti-pot fanatic based upon my communications to you. This is really not true but I do believe that you have an ethical responsibility to recognize the impact your publication has. In your November 1, 1975 issue you have made a top-level story out of an Army study of 27 individuals. The conclusions drawn on a sample size of 27 individuals really can not rate that much consideration. I am impressed with the fact that $382,000 was spent on such a limited study but I feel you do a real disservice by suggesting that a study of such limited scope does anything more than add to a growing collection of data.

The short term studies have demonstrated that pot is an innocuous chemical for a large portion of the population. Since we are talking about a use pattern which effects a sizeable portion of the population, I believe that is is imperative that we do not lose sight of the importance of adequate *time, sample* size and *experimental design* when we look at collected data.

If you want to sell newspapers then call yourselves a newspaper! If you want to be a professional journal then recognize the responsibilities that go along with the job.

Charles H. Clay
Educational Consultant-Drugs and Continuing Education
Fraser Public Schools
Fraser, Michigan 48026

NATIONAL DRUG ABUSE CONFERENCE

March 25-29, 1976 — Americana Hotel — New York City, New York

For further information contact:
Joyce H. Lowinson, M.D., Chairperson
National Drug Abuse Conference
1500 Waters Place
Bronx, New York 10461
(212) 430-3338/9

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THURSDAY, MARCH 25, 1976

3:DD p.m. - 8:DD p.m. — Registration
6:DD p.m. - 8:DD p.m — Exhibits Open; Hospitality Hour

FRIDAY, MARCH 26, 1976

A. 9:DD a.m. - 12:DD p.m. — Plenary Session

B. 1:3D p.m. - 3:DD p.m. — CONCURRENT SESSIONS

I. The History of the Evolution of the Therapeutic Community
Msgr. W. O'Brien, J. Jaffe, M.D., E. Senay, M.D., H. Mourer
II. The Role of the Regulatory Agencies
B. Stonecipher, J. Langer, S. Nightengale, M.D.
III. Basic Research in Drug Screening
C. Iannaccone, G. DeGregorio, Ph.D., R. Harford, Ph.D., I. Siassi, M.D.
IV. Epidemiology of Heroin
A. Richman, M.D., B. Gropper, Ph.D., V. Patch, M.D.
V. Special Populations — Sexual Variants
A. Fox, H. Kooden, Ph.D.
VI. Credentialing Drug and Alcohol Workers
V. Woolf, Ph.D., S. Steinberg, P. Vamos, N. Quinones, Ph.D., D. Armstrong
VII. (a) Behavioral Approaches to the Drug and Alcohol Problem
R. Hesse
(b) Public Policy Review — NIAAA: Past, Problems and Progress
M. Hertzman, M.D.
VIII The Dilemmas of Coordinating Treatment with Criminal Justice:
A Two Year Experience
A. Lissner, J. Gilmore, K. Pompi, Ph.D., D. Heit, V. Shorty
IX. Minority Approaches to Prevention
W. Harvey, Ph.D.
X. Family Therapy Approaches to Treatment
M. Stanton, Ph.D., K. Hope, M. Novick, M.D.
XI. The National Drug/Alcohol Collaborative Project
J. Carroll, Ph.D., T. Voskuhl, T. Siebold, J. Kissko

C. 3:15 p.m. - 4:45 p.m. — CONCURRENT SESSIONS

I. Variations of the Therapeutic Community
F. Cohen, M. Rosenthal, M.D.
II. Basic Research in Drug Dependence
A. Schwartz, Ph.D., E. Uyeno, Ph.D., R. Tansill, M. Cohn, Ph.D., M.D., J. Stryker, M.D.
III. Non-Traditional approaches to Drug Abuse Treatment
J. Flanzer, L. Lynn, M. Burglass, M.D., R. Beals, L. Sigman
IV The dilemma of the Asian American Drug Abuser
T. Chung, I. Yoshida, J. Yasuda, R. Wakabayashi
V. Future Funding for Drug Abuse Treatment
N. Wynstra, L. Friedland, L. Boche, B. Beaureguard, R. Adame
VI. The Drug Addict Alcoholic
B. Stimmel, M.D., H. Barr, Ph.D., L. Webb, A. Cohen, Ph.D., R. Harford, Ph.D.
VII. Methodology and Evaluation of Polydrug and Alcohol Treatment
W. Schmelter, T. Thierman, J. Davis, Ph.D., M. Galanter, M.D.
VIII Assessing the State Planning Process for Primary Prevention
R. Hesse, J. Corcoran, J. McCord, R. Horman
IX. The Free Clinic Approach to Community Medicine and Drug Abuse Treatment
D. Smith, M.D., S. Dowdy-Glenn, R. Seymour, J. Newmeyer, Ph.D., D. Inaba, Pharm.D.
X. Treatment of Drug Addiction and Alcoholism in the Same Facility
Experience and Issues
J. Mayer, Ph.D., D. Lewis, M.D., N. Zinberg, M.D.
XI. Ancillary Medical Treatment in Methadone Programs
F. Mas, M.D., B. Bihari, M.D.
XII. Take Home Methadone: Restraint, Rehabilitation, Reality?
B. Stone, V. Patch, M.D., P. Cassarino, D. Patterson, J. Orraca

D. 5:DD p.m. - 6:3D p.m. —CONCURRENT SESSIONS

I Tha Myths and Legends of the Therapeutic Community
E. Garcia, C. Devlin, M. Darcy, F. Natale
II Clinical Research with Narcotic Antagonists
T. Capone, Ph.D., L. Brahen, Ph.D., M.D., G. Lonborg, A. Thomas, D. Arnon, M.D., D. Lewis, M.D.
III Clinical and Basic Research with the Use of Barbiturates
M. Cohn, M.D., Ph.D., L. Deutsch, M.D., J. Tecce, Ph.D.
IV Long Term Evaluation of Drug Abuse Treatment
P. Coshman, M.D., F. Gearing, M.D., W. Ferris, Ph.D., A. Milman, J.D., S. Sells, Ph.D.
V Addicted Mothers and the Family
T. Morrow, M. Henderson, L. Finnegan, M.D., J. Moriarity, Ph.D., H. Foster
VI Third Party Payments and the Clinical Process
M. Segal, J. Phillips
VII Ethical Issues Involved in Relation to the Criminal Justice System
M. Burglass, M.D., G. McKenna, M.D., N. Shostak, R. Bickford
VIII Interface of Clinical and Corrections Staff in a Multimodal Drug Abuse Program
F. Agrill, G. Parker, J. Flanzer, J. Ungerleider
IX The Evolving Relationship between Prevention and Treatment
I. A. Baer, H. Wynn
X Rural and Urban Drug Abuse Treatment
R. Swanson, M. Benevenga, D. Speights, G. Hayes
XI The Decriminalization of Urinalysis
N. T. Schramm
XII Management Techniques for Drug Treatment Programs
H. Weiner, DSW, G. DeAngelis, Ph.D., C. Lincoln, H. Kahn, Ph.D.

SATURDAY, MARCH 27, 1976

E. 10:45 a.m. - 12:15 p.m. — CONCURRENT SESSIONS

I Dealing with Special Problems in the Therapeutic Community
S. Ibala, J. Martinez, H. Dibble, S. Larkin
II Basic Research on the Pharmacology of LAAM
S. Mule, Ph.D., A. Misra, Ph.D., C. Inturrisi, Ph.D., G. Henderson, Ph.D.
III The Treatment of the Opium Addict in Iran
A. H. Inaia, M.D., M. H. Maharem, M.D., N. Zuberi, M.D., J. Razani, M.D.
IV Clinical Follow Up and Evaluation of Methadone Detoxification
W. Panepinto, M. Mezritz, D. Gerstein, Ph.D., B. Stimmel, M.D.
V. Treatment of Latino Drug Abusers
M. Scopetta, Ph.D., O. King, I. Quiroga, Ph.D., J. Szapocznik, J. Garcia-Esteve, Ph.D.
VI. Accreditation and Third Party Payments
S. diMenza, R. Cohen, J. Phillips
VII. The Treatment of the Alcoholic Patient
R. Stanzione, T. Nissen, G. Gubar, Ph.D.
VIII. New Developments in Decriminalization of Marijuana
M. Falco, Esq., J. Rector, Esq., K. Stroup, Esq., Dr. J. Tinklenberg, Prof. R. Bonnie.
IX. The Evaluation of Primary Prevention Programs
E. Schaps, Ph.D., D. Falk, Ph.D., J. Corcoran
X. The Recovered Addict Returns to Work
D. Carpenter, H. Alksne, L. Koenigsberg, L. Lieberman, Ph.D., K. Wolf
XI. Evaluation of Intervention Programs
M. Haines, L. Murray, E. Gottheil, M.D., Ph.D.

F. 1:3D p.m. — 3 p.m. — CONCURRENT SESSIONS

I. Interface Between the Therapeutic Community and the Health Delivery System
S. Galser, E. Kaufman, M.D., S. Shankman, J. Densen-Gerber, M.D., N. Levy
II. Basic Research in the Pharmacology of Narcotic Antagonists
E. Cone, Ph.D., S. Weinstein, Ph.D., N. Chattergie, Ph.D., K. Verebey, Ph.D.
III. Current Needs of Drug Treatment Programs
R. Hesse, R. DuPont, M.D., V. Patch, M.D., Dr. P. Jordan
IV. The Effect of Drug Treatment on Crime
G. Nash, Ph.D., G. DeAngelis, Ph.D., J. Maddux, M.D.
V. Women in Drug Program Management — The National Association of Women in Human Services
B. Gibson, H. Manley, O. Jacob, A. Kurman-Gulkin, V. Borrok
VI. Current Trends in the Training of Drug Treatment Staff
A. Curry, Ph.D., A. Lopez, T. Kauffman, H. Hendrix
VII. Clinical Treatment and Patient Characteristics of Drug Addict and Alcohol Patients
H. Barr, Ph.D., A. Cohen, Ph.D., P. Hannigan, H. Steinberger, B. Bihari, M.D., D. Sternberg, Ph.D., M. Galanter, M.D.
VIII. The Legal Problems of Clients
R. Dickstein, J.D., B. Stone, R. Evans, P. Dananceau, J. Oracca, C. Hanson
IX. The Use of the Media in the Prevention of Drug and Alcohol Abuse
J. Hammond, T. Adams, D. Schmeling
X. The Administration of Drug Treatment Programs
M. Gissen, J.D., H. Sholl, D. Kerr, R. Myles, A. Rocklin, Ph.D., R. Seymour, G. Jackson, M.D.
XI. Involuntary Treatment — Issues and Trends
C. Leukfeld, DSW, T. Hanlon, Ph.D., D. Heit, H. Feldman, Ph.D.
XII. A Clinical Training Model for Drug Program Staff
R. Cutler, Ph.D., C. Reiner, Ph.D.

G 3.15 p.m. — 4.15 p.m. — CONCURRENT SESSIONS

I. The Interface Between the Therapeutic Community and the Criminal and Juvenile Justice Systems
F. Rogers, J.D., Hon. I. Brownstein, P. Kaufman
II. Basic Research in the Pharmacology of Narcotic Antagonists
R. Kaiko, Ph.D., D. Lange, B. Berkowitz, Ph.D., M. Braude, M.D. L. Renning Ph.D.
III. Epidemiology of Drug Abuse — Current Trends and Treatment Planning
E. Senay, M.D., R. DuPont, M.D., J. Newmeyer, Ph.D., J. F. Shick, M.D.
IV. Varied Prescriptions for Treatment Success
P. Janke, R. Bale, Ph.D., T. Rush, Ph.D., M. Quinones, Ph.D.
V The Committee of Concerned Methadone Patients Our History and Our Future
J. Orraca, D. Cattes, D. Patterson
VI. The Training of Clinicians for Quality Care
M. Galanter, M.D., M. Rosenbloom, H. Freudenberger, Ph.D.
VII. Research Studies in Polydrug Abuse
J. Phin, A. Friedman, Ph.D., A. Karras, Ph.D.
VIII The New York Experience Under the 1973 Drug Law
M. Morril, Esq., Assemblyman S. Fink, I. Glasser, Esq., A. Japha, Hon. L. Polsky
IX The Spanish Centered Program for Drug Abuse Prevention
F. Folkers, I. Kraimer
X Records and Systems in Clinical Treatment
A. Galonsky, P. T. Harris, J. King, M.D., D. Gorsh
XI Outreach Methods for Drug Treatment
M. Flaherty, D. Bennett
XII Specialized Information Resources for Community Programming
S. Lachter, L. Ferguson

H 5 p.m. — 6:30 p.m. — CONCURRENT SESSIONS

I An Open Session to Discuss the Therapeutic Community
B. Cuellis, E. Garsi, V. Moreno, R. Pruss
II Religious Approaches to the Treatment of Drug Abusers
Rev. I. Hagemann, Msgr. W. O'Brien, C. Hess, M.D., Rev. J. Allen, Rev. J. Griggs
III Infants Born to Narcotic Dependent Women
S. Kaplan, M.D., D. Reese, L. Finnegan, M.D., J. Stryker, M.D.
IV Evaluation of Employment in Drug Treatment Programs
F. Gearing, M.D., A. Karras, Ph.D., G. DeAngelis, Ph.D., D. Caplovitz, Ph.D.
V The Alcoholic Woman
C. Joseph
VI New Dimensions in Training Substance Abuse Professionals in the Black Community
W. Marshall, H. Avent, R. Fuhrberg, S. Sechon
VII Methods of Treating Alcoholic Patients
J. Tamerin, M.D., L. Freedman, M.D., S. Manos
VIII Impact of the New Patient Confidentiality Regulations upon the Relationship between the Criminal Justice and Drug Abuse Treatment Systems
J. Weissman, R. Stone, J. Orraca, P. Benedetto, Esq., E. Ballon, Esq.
IX Alternatives to Drug Abuse
M. Galanter, M.D., J. Critchley, D. Weinberg
X Clinical Research in Hallucinogen Users — Personalities and Work
A. Levin, M.D., K. Khavari, Ph.D.
XI Social Sanctions and Drug Abuse Prevention
N. Zinberg, M.D.

I 9:00 a.m. - 10:30 a.m. — CONCURRENT SESSIONS

I Accreditation and Credentialing in the Therapeutic Community
S. DiMenza, D. Kerr, D. Beutch
II. Clinical and Basic Research with LAAM
W. Ling, M.D., C. Inturrisi, Ph.D., A. Howe, M.D., E. Inwang, Ph.D., J. Stickney, Ph.D., W. Dorus, M.D.
III Clinical Research on Neonatal Withdrawal
C. Kandall, M.D., R. Kron, M.D., C. Chavez, M.D.
IV Patient Profiles in Drug Rehabilitation Programs
B. Bihari, M.D., M. Cohen, Ph.D., M. Ellner, Ph.D.
V. The Problem of Child Abuse
J. Densen-Gerber, J.D., M.D.
VI. Women Patients in Drug Treatment Programs — Current Issues
B. Rosenthal, J. Kovacs, S. Mondo, M. Aycock
VII. Approaches to Treating Polydrug Abuse
H. Angle, Ph.D., C. Tudor
VIII. The Case for Heroin Maintenance
P. Jacobs, Ph.D., N. Zinberg, M.D., A. Lindesmith, Ph.D., Lidz, M.D., R. Bayer
IX. Community and School Based Drug Abuse Prevention—Programs
A. Riddell, Ph.D., J. Fausel, J. Gregory, D. Samuels
X The Treatment Program and the Community
J. Langrod, S. Smith, M.D., M. Gissen, J.D., I. Marion, B. Bihari, M.DE.
XI Treating the Chicano Addict
R. Adame
XII. Treatment of Medically Addicted and Terminal Patients
J. Lowinson, M.D., B. Steonecipher, R. Millman, M.D.

J. 10:45 a.m. - 12:15 p.m. — CONCURRENT SESSIONS

I. The Effectiveness of the Therapeutic Community
G. DeLeon, Ph.D., R. Bale, Ph.D., C. Chambers, Ph.D., D. Litton
II. Basic Pharmacological Activity of Methadone and Other Drugs
M. J. Kreek, M.D., E. Snyder, Ph.D., T. Slotkin, Ph.D., B. Dvorchik, Ph.D.
III. Outcome Studies of Drug Treatment Clients
J. Ungerer, D. Gerstein, Ph.D., I. Siassi, M.D., J. Schut, M.D., B. Kleinhans
IV. Techniques and Tools for Program Evaluation
G. Dubin, M.D., . Bennett, C. Forrest, K. Doyle
V. Drug Use in High Risk Populations
L. Salzman, M.D., M. Burglass, L. Jones
VI. Murder, Death and Opiate Addiction
V. Patch, M.D., M. Perkins, M.D.
VII. Polydrog Grand Rounds: The Best of the Worst
J. Jacoby, M.D., D. Wesson, M.D., B. Comstock, M.D., K. Schooff, M.D., A. Raynes, M.D.
VIII. Yoga, Nutrition and Meditation Effective in Overcoming Addictive Behavior
M. Kaur, H. Singh, S. N. Singh
IX. Smoking as Drug Abuse
J. Jaffe, M.D.
X. Vocational Rehabilitation in Drug and Alcohol Treatment Programs
E. Wolkstein, R. H. Milkman, M. Burros, S. Belenko, Ph.D.
XI. Socioeconomic Factors in Communication How They Affect Counselling and Rehabilitation
R. Renteria, W. McKeever

K. 1:30 p.m. - 3:DD p.m. — CONCURRENT SESSIONS

I The Future of the Therapeutic Community
J. Densen-Gerber, M.D., J. Jaffe, M.D., Msgr. W. O'Brien, M. Rosenthal, M.D.
II The Biological Effects of Long-Term Methadone Treatment
H. Kleber, M.D., J. Bloomer, M.D., R. Langon, M.D.
III Methadone Dose, Plasma Level and Cross Tolerance to Heroin
J. Volavka, M.D., K. Verebey, Ph.D., R. Resnick, M.D., S. Mule, Ph.D.
IV Follow-Up Studies of Methadone Maintenance Patients
F. Gearing, M.D., H. Josephs, P. Cushman, M.D., B. Stimmel, M.D., I. Siassi, M.D.
V A Cities Role in Preventing Drug Abuse
J. Riggens, T. Burgess
VI Clinical Findings in Personality and Sex Differences Among Addicts
M. Cohen, Ph.D., J. Ungerer, A. Levin, M.D.
VII Approaches to the Treatment of Alcoholism
J. Kern, Ph.D., S. Paul
VIII The Causes of Drug Abuse
G. Crawford, Ph.D., E. Fogelman, E. Farley, H. Milkman, Ph.D.
IX Transcendental Meditation and Drug Abuse
J. Lowinson, M.D., M. Shafii, M.D., H. Benson, M.D., J. Marcus, R. Jones, M.D.
X Policy, Politics and Program Management in Drug Abuse Treatment
G. DeAngelis, Ph.D., L. Santora, B. Bihari, M.D.

3:15 p.m. - 4:45 p.m. — CONCURRENT SESSIONS

I A National Organization of Therapeutic Communities
Therapeutic Communities of America

3:15 p.m. - 4:45 p.m. — CONCURRENT SESSIONS

I A National Organization of Therapeutic Communities — Therapeutic Communities of America
M. Gissen, J.D., R. Myles, M. Sack, H. Sholl
II Clinical and Basic Research in Substance Abuse
K. Schnoll, M.D., S. Lund, R. Resnick, M.D., R. Burns, M. Cohen, M.D.
III Nursing the Polydrug Patient
J. Dyson, R.N., J. Lindsey, R.N., M. Greene, R.N., Panzarino, R.N., J. Jacoby, M.D.
IV Workshop on the Problem Oriented Records System
R. Pandina, Ph.D., S. Grossman, A. McAuley, G. Besson, P. Mysak
V The California Experience: The CODAP Reporting Systems
W. Spillane, Ph.D., P. Ryser, Ph.D., J. Colbert
VI The Last Milligram: From Chemical Bandage to Personal Self Actualization
T. Bottler, Ed.D., M. Pennacchia
VII The Problem of Multiple Drug Abuse
D. Smith, M.D., E. Kaufman, M.D., S. Nichols, M.D.
VIII The Pyramid Project: A National Resource Network for Primary Prevention
J. Olsen, Ph.D., A. Cohen, Ph.D., K. Thin, J. Corcoran
IX High Risk Populations — Youth
R. Nuttall, Ph.D., J. F. Schick, M.C., A. Richman, M.D., I. Khan, M.D.
X Examining Combined Treatment of Alcoholism and Drug Addiction
D. Ottenberg, M.D., J. Fleis, J. DeMatteo, H. Ball, Ph.D., G. Freeman, M. Dichter, Ph.D., G. McKenna, M.D.
XI Acupuncture in Treatment of Substance Abuse
J. Lowinson, M.D., I. Ng, M.D., S. J. Yue, M.D.

MONDAY, MARCH 29, 1976

M 9:00 a.m. - 10:00 a.m. — Wrap up Plenary Session
10:30 a.m. - 6:00 p.m. — Continuing Education in Substance Abuse
R. Millman, M.D., S. Nightingale, M.D.
(a) For Physicians
(b) For Paramedical Personnel

Sponsoring Organizations National Institute of Drug Abuse · National Federation of Concerned Drug Abuse Workers · National Council on Alcoholism · National Association for the Prevention of Addiction to Narcotics · National Institute on Alcohol and Alcoholism · International Council on Alcohol and Addictions · Therapeutic Communities of America · Greater New York Coalition on Substance Abuse · National Association of State Drug Abuse Program Coordinators · National Coordinating Council on Drug Education · National Free Clinic Council · North American Association of Therapeutic Communities · Provide Addict Care Today

ndac

Preliminary Program (Times and speakers are subject to change)

Dolphin's real-life therapy includes vocational training

By Harvey McConnell

OCEAN ISLE BEACH, N.C. — Lines of Atlantic breakers foam in only yards from four brine-beaten wooden cottages grouped in the sand dunes at one end of this small and isolated beach along the Southern coast.

The cottages form Camp Dolphin and house about 40 young male and female drug abusers in a therapeutic community now administered by the North Carolina Drug Authority and Mental Health Service, eastern region.

After a year in operation its success has spurred officials to open another similar operation in Duck Point about 50 miles north of here.

What makes Camp Dolphin unusual is that it is deliberately not modeled on any other type of TC known by its director, Fritz Kern, and Dr Burt Walden, head of the Southeastern (NC) Mental Health Center in Wilmington some 70 miles away which recently turned the centre over to management by the eastern division.

The basic philosophy is to take the abusers, almost all of whom have committed offences in addition to drug abuse, and equip them with the skills they manifestly lack — educational, vocational and social — so they can cope with society on release.

Sitting in his office-cum-living room fronting the ocean, with counsellors and clients wandering in and out, Mr Kern explained the ideas behind Camp Dolphin:

"Every program I know has started out by taking a person and breaking him down to zero and then starting to rebuild him. I have always resented and fought against this. Here, there is no sitting on a hard bench thinking over a 'commitment' or the shaving of heads or some other symbol of a 'new life'.

"We live in a family setting. We accept clients as they are and they come, as far as we are concerned, with a clean slate. We fit the program to their needs and do not fit them to a program we have made up.

"What we do is a little bit of behavior modification and a little bit of reality therapy — here and now is what we have to deal and work with. And positive behavior modification takes a long time, at least six months.

"The behavior shaped by me and my staff is based on the behavior they can expect to be made to follow in their communities.

"We live a bit primitively but this provides a sense of accomplishment, and many of these kids have never been able to accomplish anything. We want to give them social coping skills so that at least they have a fighting chance when they leave here."

Mr Kern, aged 39 years, came to Camp Dolphin from Florida where he ran the drug advisory program Switboard of Miami for a year. His background is as unusual as the camp.

A New Jersey native he taught German and biology for two years in university, moved to Florida and worked with Trans World Airlines as a hydraulic engineer before spending five years at Cape Kennedy as an electronics expert helping to assemble all the moon shot space ships and landing craft.

He moved back to Miami to teach underwater diving, welding, and photography and oceanography at Dade Junior college. Later, he joined the psyhicatric staff at the University of Miami School of Medicine before being asked to resurrect the Switboard program. He also found time to act for a year as assistant pastor of St John's Lutheran church.

When he was approached by Dr Walden, "I had the self-confidence to know that even if I don't have the answers I would do my damndest to try and find them. I had seen so many TCs that didn't work. When I was offered the chance to start a TC with no holds barred and do what I wanted within the mandates set down, I saw a place where I could really do some good."

Most clients come to the camp with poor academic records. Recently five of them took the general equivalency diploma exam and passed easily.

Vocational training has a practical objective as well, Mr Kern points out. "The skills they learn here are not manufactured, as they are in so many other TCs.

"We want to give them experience in such things as automobile repairs, welding, woodworking. They may not leave trained in these but they will have enough skill to go out and get some sort of job, even as a helper."

Camp Dolphin's Director, Fritz Kern, believes in reality therapy and vocational training for his clients at Camp Dolphin.

With the ocean on the doorstep, recreational activities include swimming, life saving, sailing and diving.

"A person leaving here may not be able at first to buy a lot of scuba gear, but if he feels strongly enough then it will be no longer than two weeks before he is back in the water. If he likes sailing enough he can crew on someone else's boat until he can afford his own," Mr Kern said.

"We are giving them a view of something better."

The camp cottages are in need of repair and rebuilding and this provides both interest and incentive for the clients.

Camp Dolphin is completely drug free. This extends to staff members who do not drink while at the camp. There are no ex-addicts on the staff.

"The only time we have talked about drugs is one evening when the kids asked me to and I answered questions for four hours."

From the day each enters, every client is made to understand that "we require that the person being here wants to be here. One of the things that Camp Dolphin is dedicated to and predicated on is that they do not interfere with anyone else's right to be here."

We tell people when they come that this is a learning place and a growing place and it is not just a place to be fed and safe."

Mr Kern knows there is more to do but he has a time limit: In mid 1976 after two years at the camp he and his wife Lucy are off to Bolivia "to settle down to live among the Indians, if they will let us." They are both studying the language via a University of Michigan course.

Mr Kern adds that after two years: "I will have gotten the satisfaction out of the job and the job will have gotten all it can out of me.

"I don't believe in the cult of indispensability — if my staff can't do it, then Camp Dolphin will have been a fluke."

New Books

by RON HALL

Alcohol And Other Drug Usage Among Junior And Senior High School Students In Charlotte-Mecklenburg

. . . by Jonnie H. McLeod and J. Denny McGuire
Charlotte Drug Education Center, Inc., (1416 East Morehead Street, Charlotte, North Carolina 28204), 1975. 102 p.

This report details and analyzes the information which has been collected over a five year period concerning the drug-use patterns amongst the youth of a North Carolina county. Information about psychological and sociological states which have been correlated to drug abuse is presented. Validity of the survey results, and prevalence of drug usage by grade, sex, and race are detailed.

Prosecution Perspectives On Drugs

. . . by Thomas B. Kirkpatrick, Jr.
Drug Abuse Council, Inc. (1828 L Street N.W., Washington, D.C. 20036), 1975.
64p.: $1.25

In a collection of edited interviews, the author has related the attitudes of twenty-five prosecutors with regard to narcotics and dangerous drug issues. Interviews were held in ten jurisdictions across the United States under formal and informal conditions. The topics covered range from the public image of the prosecutor to a discussion of treatment and punishment.

Other Books

Alcohol and Aldehyde Metabolizing Systems: Thurman, R. G., Yonetani, T., Williamson, J. R., and Chance, B., Academic Press, New York, 1974, 611 p. $22.54.

The Opium War 1840-1842: Fay, Peter Ward University of North Carolina Press, Chapel Hill, 1975. Account of the war between England and China, including an extensive treatment of the opium trade from production to consumption. 406 p. $16.

The Expected Return From Pharmaceutical Research: Schwartzman, David, American Enterprise Institute for Public Policy Research, Washington, 1975, 58 p. $3.

Occupational Alcoholism Programs: Williams, Richard L. and Moffat, Gene H., Charles C. Thomas, publisher, Springfield, 1975, 282 p. $18.50.

Facts About Alcohol and Alcoholism: National Institute on Alcohol Abuse and Alcohol, U.S. Government Printing Office, Washington, 1974, 44 p.

The Diagnosis and Treatment of Alcoholism: Forrest, Gary, G., Charles C. Thomas, publisher, Springfield, 1975. Background information, strategies of treatment, clinical readings, bib. 257 p. $14.70.

From Program To People: National Institute on Alcohol Abuse and Alcoholism. U.S. Government Printing Office, Washington, 1975, 36 p.

Synthetic Substitutes for Opiate Alkaloids: Cochin, Joseph, and Harris, Louis, Drug Abuse Council, Washington, 1975. 77 p.

Survey of Analgesic Drug Prescribing Patterns: Seitner, Philip, G., Drug Abuse Council, Washington, 1975. 274 p.

Cross-Cultural Approaches to the Study of Alcohol: An Interdisciplinary Perspective: Everett, Michael, W., Wadell, Jack O., and Heath, Dwight, B., Mouton, The Hague, 1975 676 p.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings, please send announcements as early as possible to: The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

Second Caribbean Conference on Strategies of Drug Abuse in Developing Countries — Feb. 1976, San Juan, Puerto Rico. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Third National Drug Abuse Conference — March 25-29, 1976, New York City, N.Y. Information: Joyce H. Lowinson, M.D., Chairperson, National Drug Abuse Conference, 1500 Waters Place, Bronx, N.Y. 10461.

International Conference on Alcoholism and Drug Dependence — April 4-9, 1976, Liverpool, England. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Seventh Annual Medical Scientific Conference of the National Council on Alcoholism — American Medical Society on Alcoholism — April 9-10, 1976, Washington, D.C. Information: National Council on Alcoholism, Inc., 2 Park Ave., New York, N.Y., 10016, Attention; Medical-Scientific Conference.

Sixth International Institute on the Prevention and Treatment of Drug Dependence — June-July 1976, Hamburg, Germany. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Canadian Conference on Youth, Society and the Law — June 7-10, 1976, Kingston, Ont. Information: Chairman, Canadian Conference on Youth, Society and the Law, 55 Parkdale Ave., Ottawa, Ont.

Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies — June 20-25, 1976, Toronto, Ont., Information: W. J. Gilliland, Conference Manager, Addiction Research Foundation, 33 Russell St., Toronto, Ont., M5S 2S1.

Eleventh International Conference on Medical and Biological Engineering — Aug. 2-6, 1976, Ottawa, Ont., Information: Conference Office, National Research Council, Ottawa, Ont., K1A 0R6.

First World Conference on Therapeutic Communities — Sept. 20-25, 1976, Katrineholm, Sweden. For Information: ICAA Case Postale 140, 1001 Lausanne, Switzerland.

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Worst problem in five years

Illicit drugs swamp N.Y.

NEW YORK — Law enforcement officials in New York report the city is experiencing its worst illegal narcotics trafficking problems in five years.

An increase in major narcotics rings and a cutback in police narcotics division staff are blamed.

Huge quantities of heroin and cocaine — in larger amounts than have been seen since the 1960's — are being sold openly in Harlem and the East Village.

Overdose deaths resulting from heroin are also rising, with police projecting more than 1,000 deaths this year.

An investigation of the current drug situation pointed out control of the illicit trade has shifted from the Mafia to Black and Hispanic importers and dealers, although the Mafia still retains a sizeable role in trafficking.

It was only two years ago that many New York drug officials predicted narcotics problems would decrease. Turkey's decision to ban the growing of opium poppies and the conviction of several narcotics figures should have led to the decrease,

THE BACK PAGE

Jazz greats: 'creative despite addictions'

By Harvey McConnell

BIRD, DUKE, Young, Mingus, Roach, and, of course, Armstrong. Names any jazz lover will recognize as giants, past and present.

All of them have been friends of Dr Luther Cloud, psychiatrist and vice-chairman of the National Council on Alcoholism board of directors. With the notable exception of Armstrong, they have all also been his patients because of drinking problems.

Dr Cloud has had the rare opportunity as a jazz historian and devotee — he has a collection of some 6,000 jazz records — of being able to help many of the people he has admired for their musical talent.

"One of the things that has always horrified me is how many truly great musicians, who have been formative in the history of jazz, have died at an exceptionally early age because of their alcoholism."

Trumpeter Bix Beiderbeck, 38, "who wasted most of his life drinking and playing in square bands like Paul Whiteman".

Jimmy Bland, 21, "a very fine bass player who perhaps set the stage for bass as we know it today".

Pianist "Fats" Waller, 39, "who had for breakfast what he called 'liquid ham and eggs', which was 4 oz of Scotch".

Charley Christian, 21, "one of the finest of all guitar players, who set the style for practically all bop guitar. He died of TB, but TB brought on by eight years of drinking, since he was 13.

"We think we have a teenage problem today? We think we are seeing kids drink young? It is not a new phenomenoa.

"So many of the musicians started to drink early, to play music and to die; to burn themselves out."

As they challenge each other on their instruments, musicians have a also used alcohol as a contest.

Duke Ellington considered himself the champion of them all when he finally decided to become "a retired juice addict" after 30 years.

Dr Cloud recalls that "for the last 10 years I knew Edward, I could count on one hand the number of times he had a social drink, and he always toyed with it.

"He had been a very heavy drinker and then he switched to ice cream. He finally stopped the ice cream as it was not good for his gall bladder."

Two of the most tragic, and gifted, figures he has known are Lester Young and Charley "Yardbird" Parker.

Parker and his alto sax "turned the jazz world round for his particular time and place. New York's Birdland was his memorial".

Dr Cloud met Parker after the musician, deciding he was suicidal, turned up at 3 a.m. at Bellevue Hospital and demanded to be admitted. "And he had a devil of a job getting in!"

A couple of weeks later some of Parker's friends came to see Dr Cloud and told him it did not look as though Bird was going to be released. They asked for his help.

Dr Cloud had done part of his training at Bellevue so he went along "and I saw a very fine European trained psychiatrist, who had rather a thick accent. I told him I thought Parker was functional, which is about all you can say about a schizophrenic."

The psychiatrist replied: "No indeed, if you talk to him he does not make any sense."

Dr Cloud went along to Parker and asked him what had he been telling the psychiatrist.

Parker replied: "Every day I go up to him and I say 'Doc, I've got to split this scene, I need the bread.'"

Dr Cloud translated ("What does he need bread for, we feed him?") and finally "the psychiatrist did not understand what either of us was talking about, and decided it was less trouble to get rid of Parker than to keep him, and he was discharged in my care!"

Parker was also a heroin addict but, at 34 alcohol killed him. He died in a Harlem apartment after a binge of several days.

Lester Young, who played tenor sax with Count Basie for years, met Dr Cloud when he was at his lowest ebb in a checkered career. Young never touched heroin: "He told me one day 'Man, I never auditioned.' But, boy, the booze got to him."

Young's problems were so enormous that he left his wife and two children and moved into a second-rate Manhattan Hotel. Night after night he would sit on the fire escape and watch his peers go into Birdland across the street.

Young was notoriously doctor and needle shy and it was only after several months of friendship that he discovered Cloud was a medical man.

Dr Cloud said that in addition to his musical talent, "Lester Young was the most blasphemous person and profane man. He had the most lyrical way of expressing obsenity I have ever heard. It was poetry, but somehow you never seemed to mind because it all came out right."

Young finally recovered enough to stop drinking for a while and returned to playing again at Birdland and other clubs. Then he was offered a Paris concert date.

Dr Cloud said: "I was very uneasy about it because I knew he had a lot of friends in Paris. But, finally we decided to let him go and it was the first time Lester asked me to do anything dishonest — fake his vaccination certificate, which I did not do."

Young was a hit in the French capital. Then he started to drink and to bleed so badly from esophageal varices he was put on a plane home. He was bleeding when he got on and he was bleeding when he got off.

"It was a Saturday when then, and now, I play handball in New Jersey. I was driving back when I heard of his death on the radio."

But the list is not all tragic. One friend of long standing is Max Roach, drummer and composer and one of the first musicians to use jazz as protest.

Roach often smoked marijuana and would then drink. He got into the habit of letting his protest rise to the surface by going out and trying to hit policeman with their nightsticks. He ended up in Bellevue.

Dr Cloud recalls that at first "he was angry at me for being white, which I couldn't help. I explained that to him several times!"

Dr Cloud helped get Roach out of the club environment and he now lives and composes his music in Massachusetts.

Some recovering alcoholics are trumpeter Bobby Hackett and singer Anita O'Day, now making a comback. "I heard her recently and she is singing as beautifully and swingingly as she ever did."

Louis Armstrong never had a drinking problem. Dr Cloud said that was exemplified at a charity concert the great trumpeter agreed to give in a small village on the Outer Banks in North Carolina.

He watched fascinated as Armstrong warmed up for 30 minutes. Asked why he took so much trouble for such a small date, Armstrong replied: "I always play for myself."

Despite several invitations, it was not until 4 a.m. on the beach that Armstrong drank his first gin.

One of Dr Cloud's most memorable moments was to be present when Ellington recorded his composition La Belle Africans. Duke was on piano, Roach on drums and Charley Mingus — "who is 6'2" and 250 pounds when he diets, and 350 pounds when he doesn't, and whom I have introduced to many people who are afraid to shake his hand —" on bass.

"There they were: Ellington, the senior statesman at the time, debonair and sophisticated; Max, usually mad at everybody, but respecting Ellington; Mingus, mad at both of them in particular, but respecting both of them.

"We held our breath hoping they could finish without a break because it was so good and we felt it would never be able to be recaptured. And they did."

Dr Cloud adds. "Some people have said to me that creativity is brought about by alcoholism. I think quite the opposite. I think that people are creative in spite of their illness and not because of it."

One thing Dr Cloud has never tried to do is sit in with any musical greats. He does not play a note.

Although countless jazz musicians were addicted to alcohol or drugs, Louis Armstrong never had a problem. He 'played for himself'.

Duke Ellington gave up alcohol in his later years in favor of ice cream, another 'vice' he had to give up because of health problems.

Scientist sees long-term pot risks

By Anne MacLennan

TORONTO — A Canadian scientist has warned that society will suffer severe health and economic consequences if cannabis use becomes widespread.

Dr Eugene LeBlanc, a pharmacologist and until now a non-combatant in the cannabis debate, says in terms of society as a whole, cannabis poses a more serious threat than drugs like thalidomide.

He said he was speaking personally and strictly from a public health point of view.

"It sounds callous but as long as drugs produce dramatic toxicities, we are going to be relatively safe because we have got a fairly sophisticated medical system. Drugs that produce extremely rare disorders or brand new disorders get the whistle blown on them pretty fast.

"I don't want to compare apples and oranges but I don't think cannabis is going to have a dramatically salient health effect. We'd have seen it by now," said Dr LeBlanc.

"But, on a societal basis, and for that reason — that we do not see its effects quickly — cannabis is far more threatening. It's insidious. It belongs to the group of substances which will produce delayed clandestine health costs — ones which are imbedded in the normal kinds," he said.

Dr LeBlanc is assistant head of the Research Division and a scientist in Biological Studies at the Addiction Research Foundation of Ontario, and assistant professor of pharmacology, University of Toronto.

"No reasonable person would say that regular, widespread cannabis use is going to improve the health.

"So, we have two options. Either it will do nothing or it will worsen it. I think between the two options, the evidence is enough to predict with reasonable certainty, there will be a worsening.

"My position would be: So what else is new? Given that you have an active substance with high fat solubility, you know if you give enough of it long enough, there are going to be risks.

(Interview continues page 7)

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Weighing up pot situation

LAPD uses mini-scales

By Saul Abel

LOS ANGELES — Nowadays, when Californians refer to the "scales of justice," they are speaking literally.

Since Jan. 1, when California's liberalized marijuana law became effective, Los Angeles police officers have been carrying miniature scales to help them determine the quantity of the drug a suspect possesses.

Under the new law, simple possession of less than one ounce subjects the adult offender to a traffic-ticket type citation and a fine of not more than $100. Formerly, the same offence could be considered a felony, with possible penalties of up to 10 years imprisonment.

One dramatic impact of the legal change will be upon persons serving a state prison sentence for simple possession of marijuana.

According to State Adult Authority Chairman Ray Procunier, parole dates for such individuals will be reviewed, with the aim of granting them an early release on parole.

Another group immediately affected is an estimated half-million Californians who now can petition the court to purge their old marijuana arrest records. The new law also provides that records of those arrested for possession of the

(See — Mini-scales — Page 5)

"Isn't there some other way a guy can get in shape?" That question is now being put to the Saskatchewan public via television commercials produced by Aware, a program for responsible attitudes to alcohol. A full report on the Aware program, an arm of the Saskatchewan Department of Health, appears on The Back Page.

BC Government quashes provincial commission

By Tim Padmore

VANCOUVER — British Columbia's Alcohol and Drug Commission has been dissolved.

Health minister Bob McClelland announced the move Jan. 13 after a meeting with commission chairman Peter Stein who described the meeting as "cordial and constructive".

Mr. McClelland said programs supported by the commission will be evaluated individually and those determined to be worthwhile will be administered directly by the health department.

The commission staff of approximately 30 civil servants will be maintained.

Mr Stein's appointment, which paid him $38,500 a year, was terminated effective Jan. 31. The other five commissioners were fired as of Jan. 15.

Mr. Stein said he would be happy to remain to "liaise" with the new administration, but there has been no indication from the health department he will be offered another job.

Meanwhile, Mr. McClelland has called for co-ordinated effort by the departments of health, human resources and the attorney-general to attack the problem of drug addiction.

With the present approach, one agency's "successes" can sometimes make the total problem worse, he said in a recent interview.

Recent large drug seizures by the Coordinated Law Enforcement Unit (CLEU) provide an example, he said, with the subsequent drug shortage leading to higher prices which, in turn, force the addict to commit more crime to support his habit.

Mr. McClelland indicated he favors compulsory treatment of addicts, along the lines recommended in the 1973 Matheson report, which urged adoption of a system involving "quarantining" addicts for up to two years.

The health minister said plans are to set up an interdepartmental committee to handle addiction problems.

Until recovery

Alcoholic doctors should quit

By Alan Massam

LONDON — One of Britain's leading medical authorities on addiction has spoken out on the vexed and sensitive question of the alcoholic doctor.

Dr Griffith Edwards, director of the Addiction Research Unit, Institute of Psychiatry, London, believes that when a doctor is suffering from alcoholism he should give up for the time being **ALL** clinical responsibility.

He makes this uncompromising stand in the *Lancet* and at the same time calls upon the profession to intervene at an early stage when they see a colleague with a drinking problem.

Dr Edwards says alcoholism is not a subject particularly well understood by the medical profession since it is given inadequate attention in the medical curriculum. Consequently when a doctor begins to drink too much he or she may not understand what is happening and colleagues often do not know how to respond helpfully.

"For the doctor alcoholic, the familiar history is therefore of a period of very dangerous drinking during which his colleagues have turned a blind eye, with the story then ultimately developing to a crisis which is met with misunderstanding

(See — Alcoholic — Page 5)

Ontario's liquor outlets can now stock 'pop'

By Karin Sobota

TORONTO — An amendment to Ontario's Liquor Control Act will enable Government-controlled liquor outlets in the province to stock non-alcoholic beverages for sale to the public.

The inclusion of the amendment in the Act, approved Jan. 2, does not mean dealcoholized beverages *must* be made available to consumers through Liquor Control Board of Ontario retail outlets, (a monopoly in the province).

At present, there is only one producer of a dealcoholized wine in Canada, Carl Jung Wines, Canada Ltd. Their wines are now being sold in delicatessens and some food stores in Ontario and Hull, Quebec. But the company is now asking the LCBO's Chief Commissioner, General George Kitching, and his Board, to grant the listing of three of their wines in LCBO stores.

The wines, which contain less than one half of 1% alcohol, have been available in Europe under various brand names for 70 years.

(See — No-Liquor — Page 6)

... INSIDE

Breath-test proposals under fire

Report — Page 4

Robert Weppner

US school develops new approach to verifying and banking drug data

By Thomas Hill

MIAMI — An organization here with an intriguing new approach and six federal grants that bring in approximately $2½ million a year, may be on the way to solving one of the basic problems that people in the drug addiction field have been struggling with for years.

The problem: how to get reliable, reproductible research data — so thoroughly verified as to be totally convincing to others in the field.

The organization with the new approach is the Division of Addiction Sciences at the University of Miami School of Medicine.

Dr Robert S. Weppner, an anthropologist who is its director, explains that one of the division's primary goals is the development of verified systematic theory relating to drug abuse.

The organization is multidisciplinary — staffed by experts in such diverse fields as anthropology, social psychology, sociology and demography and some of their sub-branches — and it can therefore develop data using the different approaches of the various disciplines and, in effect, check one set of findings against others for verification.

In an interview with Dr Weppner and Duane C. McBride, deputy director (a sociologist), **The Journal** learned that a major asset of the Division of Addiction Sciences is an unusually large, varied and well integrated data base.

"We've got data from the criminal justice system, the school system, the large county hospital, and all 10 of the drug treatment programs in Dade County," Dr Weppner said.

"It's all computerized. It's probably one of the best data banks in the world."

The computerized data system was organized by Dr Clyde B. McCoy, director of the division's Center for Theoretical and Empirical Social Research on Drug Abuse.

The heart of the system, according to Dr McCoy, is what he calls "The Quick Interactive System," or QUICK, which allows large and varied data sets to be stored, updated, recoded, merged and manipulated quickly. It features simplicity, ease and flexibility of access to data, and economy in researchers' time.

One objective of current studies is to define the extent of drug abuse in Dade County, which has a population of more than 1¼ million and an area (2,042) square miles) larger than either Rhode Island or Delaware.

"Most of the time drug abuse is studied in captured populations," Dr Weppner explained.

"You study a group of hospitalized addicts, like the population in Lexington Hospital. Or you look at a prison group. Or you study college populations. So you get isolated data on drug abuse in a circumscribed segment of the total population. What we want to do is to integrate all these perspectives."

Outlining some of the directions in which research activities of the Division of Addiction Sciences have been tending Dr Weppner and Mr McBride mentioned:

- Studies of the excessive use of over-the-counter drugs and the results of such excessive use; the development of recommendations for dealing with this problem.
- Development of a technique that holds the promise of (a) being able to predict new fads in drug abuse a year or two before they come into vogue and (b) identifying the segment or segments of the population that will be involved.
- A study of the extent to which individuals who diagnose or prescribe for the treatment of alcohol problems in a hospital emergency room, are influenced in their decisions by the age, race and sex of the patient.
- Research that has identified a large population of drug users for whom existing treatment programs are unable to provide the needed treatment services.
- Analysis of a population that presents a problem to all investigators engaged in human research (the patients lost to follow-up), identifying certain characteristics that could be useful in reducing the bias of follow-up studies.

The focus is strictly on social and behavioral research: The Division of Addiction Sciences is not engaged in either pharmacological or physiological studies.

"There's plenty of need for good research in the areas in which we have some expertise," Dr Weppner said.

Addicts are 'mumbling GPs'

Doctors warned of patient trickery

By Harvey McConnell

LONDON — Many young drug addicts in Britain are experts at tricking or threatening unsuspecting family physicians into giving them National Health Service prescriptions for drugs.

The depth of their scheming has emerged in a study of men and women addicts attending clinics in two London hospitals. They told researchers that the methods are called "mumbling the GP".

Many addicts first visit a physician who has prescribed quite legitimately in the past for a friend. The time of the visit to the doctor's office is vital.

Addicts said they aim to visit the office when it is full of waiting patients. If there are a number of children waiting, so much the better.

The addict tells the physician he wants to register as a temporary patient, and he gives his real name but a false address in the district. He explains that he has recently moved from another town and has finished the prescription given to him by his physician there of stimulants for depression, or barbiturates for insomnia.

Resorts to sob stories such as "my parents were killed recently in an automobile accident" or "my wife died in labor" are also tried out on the physician.

If, despite this, the physician says "no" to the request, then the bogus "patient" will refuse to leave the office and will threaten to make a scene.

The report adds that "with little time, and a full waiting room, compliance is the quickest solution to this difficult problem, particularly if there is an implied threat of disturbance".

The prescription, however, is not the end of the affair. Most of the "patients" will return for repeat prescription and the physician will soon find that friends of the "patient" will show up as well with a request for drugs.

Many addicts admit they steal cards from hospital outpatient clinics run for epileptics. These are used to obtain barbiturates from casualty officers at other hospitals as well as from family physicians.

On weekends when outpatient drug dependence clinics are closed, addicts will try to obtain drugs from casualty departments in hospitals by presenting their clinic attendance cards.

Family doctors are advised by the authors of the study, which appears in the *Journal of the Royal College of General Practitioners*, that they must always be suspicious of young people who register as temporary patients and soon afterwards ask for drug prescriptions.

Cigarettes

DRUGGIST CLEARS SHOP —— AND CONSCIENCE

ST. PETERSBURG, Fla. — A pharmacist here has removed all tobacco products from the shelves of his neighborhood drugstore in an attempt to make peace with his conscience.

Roy Williams placed a sign in the window of his store noting that cigarette smoking is regarded as a contributing cause of cancer, emphysema and heart attacks.

"In view of the above information and my personal concern for your health, I can no longer in good conscience continue to sell cigarettes," the notice said.

Mr. Williams, who hopes other druggists will follow his lead, said he felt it was hypocritical to sell people both medicine to cure their health, and substances which would be hazardous to their well-being.

And in this camp, Dr...

Young and old are two hostile forces

BANFF, Alta — Psychiatrists are not comfortable with aggression in young people and prefer to emphasize their control over it rather than deal with the underlying causes of it.

This is so whether the aggression is associated with drug or alcohol abuse or other acting-out behavior and although all psychiatrists try to explain aggressive behavior in young people, few of them actually understand it.

These criticisms were made at the Canadian Psychiatric Association's annual meeting and Dr Jalal Shamsie of University of Toronto suggested the explanation may lie, in part at least, in intergroup hostility — the kind of hostility seen between different racial and/or religious groups.

Gail Geltner

Dr Shamsie, an associate professor of psychiatry, said: "I suggest that for the first time in human history, the young are not simply a younger version of the adult population but a separate group — a group that looks different, feels different, and has its own language, dress, literature and values. Therefore, we have two groups in our society —the young and the old.

"Inter-group hostility has been used by social psychologists in the past to explain hostility and aggression between Negroes and Whites, Protestants and Jews, Christians and Muslims, etc."

He attributed aggression exhibited by youth in drug-taking, drinking and acts of delinquency,to inter-group hostility.

In previous history, he said, the young have always been associated with adults in work and in pleasure. Clothes were the same, only on a smaller scale; they ate the same food and talked the same language. They aspired to the same things and held the same values. This has changed, however, since World War II.

For inter-group hostility, four conditions must be met — visibility of the groups; contact between the groups; competition between the groups; and differences in values and behavior patterns, Dr Shamsie explained. All four are met by young and old, and provide fertile ground for conflict.

"There is visibility — each group can recognize the other almost instantly. As for contact, any home which has teenagers has two opposing camps constantly at war.

"The third condition — competition — concerns the small units in which we live. The fact that our pleasures are so different leads to competition for space — for the radio, TV, car, etc. Lastly, we do not need to emphasize these two groups' differences in values and behavior patterns."

Dr Shamsie said he was not pinpointing the aggression of one specific teenager toward a specific adult but explaining that young people see adults as members of an opposing team toward which they feel hostility.

The same situation exists among adults, he said.

"When they see a young person with long hair, jeans, listening to his own music, behaving in his own way, they feel a certain hostility towards this youngster — whom they don't know as a person but only as belonging to a different group."

Thus, he suggested, psychiatrists within the adult group feel the same hostility toward young patients.

It might explain, in part, he said, their failure to deal with youthful aggression.

Satori prepares addicts for new, drug-free life in the "real world"

By Mary Hager

PALO ALTA, Cal. — Satori means "enlightenment in Zen. But, for a number of ex-addicts, it also means "clean up, get your head on straight, and learn to live in the real world".

For Satori is the name given in 1971 to an innovative drug treatment program at the Palo Alto Veterans Administration Hospital, devised as an outgrowth of a 1969 VA policy of treating drug dependency as a medical illness.

Started by a group of Stanford University psychiatry professors, Satori is a community for the treatment of drug-dependent veterans. About 380 have been treated since the program, which accomodates 21 people at a time, began.

The goal, according to director Dr Vincent P. Zarcone, Jr., is complex and "involves a change in the self-identity and life style of each of its members.

"The community perpetuates itself by taking on new members to replace those who have returned to society."

In a recent publication, Dr Zarcone compares treatment in Satori to treatment of medical illness in a hospital.

"It is a process that occurs within a limited period of time: The individual enters treatment, is treated, and then leaves."

He feels this is a major difference between Satori and Synanon. In the latter, people are trained to live within an alternative life style and are expected to stay.

The brochure for prospective Satori patients lists three goals: "Clean up, get your head on straight, and learn to live in the real world." It also states: "It is tough for a drug abuser to reach these goals. You have to be out front with your feelings and behavior or you wont't make it. Secretiveness, holding it in, and keeping it to yourself, ensure failure."

The program has three phases and lasts from 16 to 28 weeks.

Applicants are screened by a committee of Satori members and staff. Accepted for the first phase — cleaning up — the applicant must sign a probationary contract and is restricted to the hospital ward. Breaking the contract can lead to expulsion.

At the end of the first phase, a "progress and planning" meeting is held. If the committee is satisfied the patient is involved and trying, he is accepted as a regular community member. He may now leave on pass, but only with an approved person.

While this allows for relapse into drug abuse, "we feel this is a risk we have to take. The kind of abstinence that depends on locked doors for its enforcement is of absolutely no permanent value to the patient," said Dr Zarcone.

If, after four weeks or more, the patient is judged to have made satisfactory progress, he is given senior status and expected to orient himself to the demands of the outside world.

At this point, the patient may find a job, become involved in a job training program or go to school. When he successfully completes the transition to the outside world, he may leave the community, maintaining ties through an aftercare program.

Satori is "properly described as a complex therapeutic community," said Dr zarcone.

"This means we use a combination of: (1) social pressure to persuade people to change their ways of relating to others; (2) individual and group psychotherapy; (3) psychoactive drugs."

Satori has both a task orientation and an emphasis on socialization. It views drug dependency "as something the patient has to grow out of in a family setting. He has to learn new ways of defending himself against anxiety, protecting his self-esteem, maintaining his sense of identity and cooperating with others in accomplishing tasks," said Dr Zarcone.

He believes vital features of the program are voluntary participation, the "out front" attitude which means patients are confronted with the meaning of their behavior, and self-regulation by community members.

Therapy usually begins with methadone detoxification, but only to buy time. "We believe social-psychiatric intervention is more important and that methadone maintenance is not a solution by itself."

Early follow-up studies showed that of those who were discharged after at least six weeks in the program, 46% were on methadone after the end of the first year.

Also, a higher percentage of those who participated were found to be heroin-free after the first year, free of arrest or conviction, and working or going to school, than those who were not treated or had only been in Satori a short time, he said.

Dr Zarcone acknowledged Satori is not "the answer" to heroin addiction and "there isn't any such answer in prospect".

But he believes Satori's experiences could be applied to any residential drug dependency program committed to removing the dependency.

Satori treatment costs between $1,000 and $2,000 for each patient but "these costs are not high in comparison with the $350 million that the traffic in narcotics is estimated to have cost US society in 1967 alone," said Dr Zarcone.

**Drug Addicts in a Therapeutic Community: The Satori Approach* York Press. $14.00

ASH talk

Propaganda backfires anti-smoking plan has boomerang effect

By Harvey McConnell

LONDON — Anti-smoking propaganda has been so successful among school children in Manchester that educators are now worried that their efforts could produce a boomerang effect.

Ms Patricia Hobbs, researcher at the University Hospital of South Manchester, told a conference here organized by the ginger group Action on Smoking and Health (ASH), that "in our zeal to help young people cope with the social and other pressures to smoke, we may distort what we know the effects of smoking are."

Research by colleague Dr Ann Charlton found recently that 89% of a sample of high school children "thought that smoking was the major cause of cancer."

In addition, she found that among many of the children "cigarette packets were stated as a source of information about cancer, even though the obligatory warning (about health dangers) does not mention cancer. But this is how they interpret it."

Ms. Hobbs admitted the situation was worrying.

"Publicity about the link between smoking and lung cancer has penetrated schools in the Manchester area so well that some pupils now feel smoking is the only cause of cancer.

"This type of misconception can boomerang, because once they know of one case of cancer where the person did not smoke, it could appear to disprove all the arguments about the danger of smoking."

Ms Hobbs said methods used with children in Manchester start by first explaining what carcinogens are. These are related to the past: the dangers of soot for chimney sweeps in the 18th century; oil for cotton spinners at the beginning of this century; and recently, oils used in the machine tool industry.

Ms Hobbs said that research has shown that even if parents smoke, they can steer their children towards a non-smoking attitude if they display the correct response.

Ms Hobbs said that in the case of the pregnant women smokers the attitude should be that it is just as important for the expectant fathers to give up smoking as the expectant mothers.

Cannabis breath tester developed

LONDON — British police are to get a new cannabis detector which has been developed by Government scientists and Analytical Instruments Ltd. of Royston, Hertfordshire.

The detector incorporates a pump which can draw air through a probe and deposit any particles in the airstream into a special chamber.

The particles are deposited on the adhesive face of a tape strip which can be moved through the chamber for successive sampling of "suspect areas".

An investigating officer examines particles sticking onto the tape with the instrument's microscopic viewing system. The microscope and the detector's pump are powered by a reachargeable nickel-cadmium battery mounted in the handle.

A spokesman for the manufacturers explained that the detector was expected to have considerable forensic potential because the minute hairs of the cannabis plant (which are easily broken off when the plant is in the dried state and even occur in some forms of the resin) have a very characteristic shape when viewed microscopically.

The detector allows samples to be retained for further examination.

Kissinger's help enlisted

US plans two-way attack on drug abuse

By Charles Marwick

WASHINGTON — The US government is planning both diplomatic and budgetary steps against their drug abuse problem.

President Gerald R. Ford has spoken with the political leaders of Mexico, Colombia, and Turkey, exploring the possibility of strengthening cooperation with these countries in controlling illicit drug trafficking.

At the same time, Mr. Ford indicated he intended to provide sufficient funds in his forthcoming budget to implement all of the major recommendations contained in the White Paper on Drug Abuse (**The Journal** Dec., 1975). He endorsed the White Paper — the first word from the White House on the document since it was issued in October.

The report had been cirticized by some government agencies here in part because it appeared to concentrate on treatment efforts rather than emphasizing control of illicit drug traffic.

However, the Paper did urge efforts to reduce illicit drug supplies and the President's diplomatic manouvers were clearly directed at attempts to control the entry of illicit drugs into the US. Whether these efforts are likely to have even a modest success at reducing, never mind eliminating, the illicit drug traffic is another question, however.

Washington observers are sceptical, partly because of strained relations with Mexico over the banning of the entry of Mexicans to the US for casual labor, domestic service, and farm work.

In recent years, following the agreement between the US and Turkey to cut poppy growing, much of the illicit heroin entering this country has come from Mexico. Additional supplies of heroin are also coming from Colombia, the drug being routed through Mexico because of the ease with which it can be ferried across the southwestern border between the US and Mexico, usually in light aircraft.

Taking note of this situation, which he described as a "worsening one", the President said he had ordered Secretary of State Henry J. Kissinger to explore with the Mexican government, opportunities for improved control of illicit drugs from Mexico. The President also asked the Domestic Council Drug Abuse Task Force (the authors of the White Paper) to present specific recommendations for controlling illicit drug traffic.

Mr. Ford said he had, nevertheless, begun to take "strong action" to deal with the problem. "I have spoken with Presidents Luis Echeverria of Mexico and Alfonso Lopez-Michelson of Colombia and with Prime Minister Suleiman Demeril of Turkey in an effort to strengthen cooperation of other nations involved in the fight against illicit drug traffic," he said.

"I shall call upon Congress to enact my proposal for mandatory minimum sentences for drug traffickers," he continued, "so those who are spreading this evil throughout our communities will be put behind bars where they belong.

"I urge Congress to ratify the Convention of Psychotropic Substances, so we can fulfill our obligations to the other nations of the world to see that strong international controls exist for all drugs."

Inflation hits UK pot

LONDON — Inflation has increased the price of most things in Britain including cannabis.

A report from a voluntary agency in London known as the Blenheim Project says the drug now costs between $55 and $70 an ounce — compared to half that price two years ago and less than $25 an ounce in 1969.

Unfortunately, however, the increase is not reducing the problem of drug abuse in Notting Hill, where the Blenheim Project operates.

More and more drug abusers known to project workers are turning to barbiturates which are cheap on the London black market and easily obtained. Twenty-five young people known to the project died during the 15 months reviewed in the report — most of them from barbiturate poisoning.

Criminal Code changes draw criticism

By Bryne Carruthers

OTTAWA — Concerns are being raised about the stringency and seeming inflexibility of the proposed changes under the Criminal Code to the alcohol Breathalyzer law in Canada.

A central concern is that the existing law, under which drivers suspected on "reasonable grounds" of being intoxicated are required by police to take a breath test, already puts drivers in the position of presenting evidence against themselves — the reverse of Canadian legal tradition.

The proposed changes, however, would allow police to set up roadside spot-checks for testing drivers merely on the basis of "reasonable suspicion", rather than the current "reasonable and probable grounds," and would represent an even greater infringement of civil rights.

Critics of the proposed changes have also noted that a portion of the original legislation, which was to provide a mechanism for the accused to have a legal sample of his breath maintained for private analysis, still has not been proclaimed. This is supposedly because experts have still not developed a satisfactory container for retaining the breath sample.

The Association of Criminal Lawyers has cast some doubt on the accuracy of police station breath sample tests. Thus, the lack of an independent check represents a further infringement of basic civil rights, say critics.

An even more emotional complaint is that the whole breath-testing approach, which seems to have little deterrent effect, tends to hurt individuals who need to drive for a living more than it hurts people able to do without a car while their licence is suspended after a drunk driving conviction.

Another provision of the original legislation — the option for a judge to provide a conditional licence to people who drive for a living, such as truckers, salesmen, taxi drivers — has been rendered next to useless because the courts have ruled that provincial legislation supercedes the Criminal Code.

In Ontario and other provinces, driving laws stipulate an automatic drivers licence suspension for those convicted under the Breathalyzer provisions.

Critics have suggested these automatic suspensions can cost some individuals their jobs and their pensions.

Eldon Wooliams, Conservative member for Calgary North, and a lawyer, says even armed robbers do not face this kind of penalty and loss under the law.

The new penalties under the proposed Criminal Code changes would require a minimum fine of $50 and a maximum of $2,000, or up to six months in jail, or both, for a first drunken driving conviction; a minimum of two weeks in jail and a maximum one year in jail for a second offence; and a minimum of three months and a maximum of two years in jail for a third offence.

All of this would be in addition to the automatic licence suspension and the criminal record.

Meanwhile Justice Minister Ron Basford has recently introduced other changes to the Criminal Code which would require narcotics dealers and murderers to show why they should be granted bail (as is now required for repeat offenders, bail-violators and non-residents).

These changes are forerunners of the federal government's planned "peace and security" legislative package expected to be introduced this spring in Parliament.

Mr. Basford said that in Vancouver, where drug trafficking is the most serious, narcotic dealers can be out on the street again the next day. In some instances, the dealers have used the time out of jail on bail to sell drugs to cover the costs of legal fees or even to build up a "nest egg" for use after release.

The "peace and security" legislative package is also expected to include provisions to tighten parole.

Pot use declines in liberal Oregon, US arrests rise

WASHINGTON, DC — The Federal Bureau of Investigation reports that marijuana arrests in the US rose to 445,600 in 1974, comprising nearly 70% of all drug arrests in the country.

At the same time, new survey results from Oregon show continuing public support for decriminalization and an apparent decrease in marijuana use since the state removed criminal penalties in 1973.

Keith Stroup, director of the National Organization for the Reform of Marijuana Lawa (NORML), called on President Gerald Ford to follow the recommendations of a White House task force which recently advised de-emphasizing national anti-marijuana efforts.

"While a nationwide survey by the National Institute on Drug Abuse shows that 86% of the public no longer favors sending marijuana smokers to jail," said Mr. Stroup, "an estimated $600 million is to be spent each year on marijuana enforcment.

"The frightening result is seven out of 10 of all drug arrests in this country are for marijuana violations. The annual toll is almost a half million of otherwise law-abiding citizens tragically and needlessly caught up in a heavy-handed criminal justice system."

The survey in Oregon, a follow-up of one in 1974, reports the latest public attitudes and patterns of marijuana usage since criminal penalties were removed two years ago.

In addition to finding a 1% reduction in the number of adults currently using marijuana, this latest survey found a majority of Oregonians (58%) continue to favor the approach of the new law.

The survey also indicated that non-users gave lack of interest and fear of possible health hazards, rather than punishment, as the dominant reason for not using marijuana.

The survey was commissioned by the Drug Abuse Council, a Washington-based consortium of private foundations.

Adults 'kick the habit' youths smoke more

OTTAWA — The percentage of non-smokers in the Canadian populace over 20 years of age has increased steadily from 47.2% in 1965 to 53.9% in 1974, according to the latest study by the federal health department.

But among teenagers, smoking has become a more serious problem during the past decade — perhaps a parallel with the increasing abuse of alcohol.

The percentage of non-smokers among teenagers 15 to 19 years of age has decreased almost 5% between 1965 and 1974, from 68.9% to 64.3%. Much of this is due to the decline in non-smokers among teenage girls; non-smoking among teenage boys has remained relatively stable.

Perhaps of more concern, more of the regular teenage smokers are smoking more heavily and frequently than in the past, thereby developing the stronger smoking habits that many of the older generations have been finding so difficult to break.

The health department noted an increase among male teenagers who are regularly smoking 11 to 25 and more than 25 cigarettes a day, as well as an increase among all female regular smokers with the exception of those aged 25 to 44 years of age.

An encouraging sign is the fact there seems to have been a levelling off within the past few years in the increase in regular use of tobacco by teenagers.

In previous years, there had been a significant increase in regular smoking among male and female teenagers. The overall increase between 1965 and 1974, even with the levelling off, is 3.1%.

Quebec still maintains the dubious distinction of having the lowest percentage of non-smokers — 48% among all age groups. British Columbia, the province with the largest narcotic problem, showed the greatest rise in non-smoking, with an increase of 11.4% in non-smokers between 1965 and 1974.

BC also has the lowest percentage of male regular smokers (37.7% compared to 54.9% in Quebec), while Ontario had the lowest percent of regular female smokers (28.4% compared to 36.1% in Quebec).

UK cuts smoking and drinking

By Alan Massam

LONDON — Increased duty on alcoholic beverages and tobacco products had the effect of reducing the consumption of beer, foreign wines and cigarettes during 1974-75, the annual report of the Commissioners for Customs and Excise has revealed.

But the overall consumption of alcoholic drinks — including spirits and home-produced wine — increased marginally by 1.3%, from 32.0 to 32.4 million proof gallons.

Exports of whisky went up by 8.7% from 82.4 to 89.6 million proof gallons. The beer consumption fell by 0.3% to 39,100,000 bulk barrels.

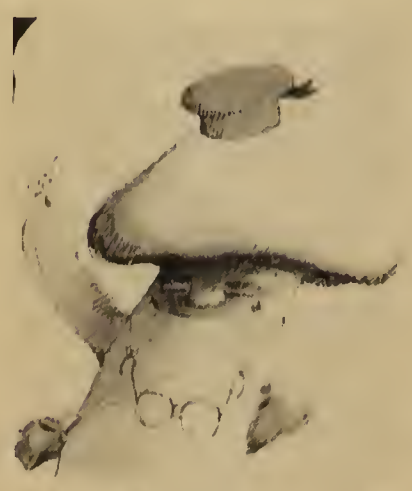
The March 1974 duty increases were so heavy, however, that receipts were considerably up. On beer, for example, they yielded $933,868,500 which was 23.4% higher than that received the previous year.

Consumption of imported wines decreased for the first time in five years — by 7.8%, from 67,900,000 gallons to 62,600,000 gallons. This, however, still produced an increase of duty of 31.0% — from $167,250,750 to $219,063,250.

The report also reveals that the consumption of tobacco fell by 6.8%, possibly due to anti-smoking propaganda by health agencies as well as the increased duty cost.

66th Report of the Commissioners of Her Majesty's Customs and Excise, Her Majesty's Stationery Office: £2.35p.

Nasty Mr. Mushroom to be a star



The sinister Mr Mushroom and other characters in the children's book 'The Hole in the Fence' may become stars of an animated film produced by the National Film Board. The Federal Health Department initiated the book which stresses societal values.

OTTAWA — The federal health department's experimental and innovative "Project Vegetable Farm", with a cast of vegetables learning the hard way about the rosy and the darker sides of life, may reach the silver screen.

The National Film Board, renowned outside Canada for its award-winning documentaries and shorts, is testing a sound-film, animated strip of the story and characters that are already a success in the educational storybook *The Hole in the Fence* (**The Journal**, September, 1975).

Meanwhile, education departments and agencies in a number of provinces have reacted enthusiastically to the storybook approach to fighting drug abuse, which features the reinforcement of broader values rather than the traditional and startlingly unsuccessful scare techniques.

In Manitoba, the Alcohol Foundation has ordered 700 English copies and 300 French copies for study and use in a pilot project later this year in Winnipeg and rural schools.

Newfoundland plans a pilot study of its own in April, to see how well the storybook will fit into its education curriculum.

Nearby Nova Scotia has ordered 400 copies, also for testing of acceptance in the provincial education curriculum. And the Nova Scotia Commission on Drug Dependency is trying to promote its use in schools.

The British Columbia Alcohol and Drug Commission is also recommending the storybook be used in BC's educational system.

And Ontario's Addiction Research Foundation has agreed to have regional directors promote the book's use by local teachers and to buy some English and French sets for testing.

Meanwhile, the federal health department has already decided to combine the teachers' guide and activity guide into one volume. And it is preparing to extend the program to new age groups.

For those who missed the original coverage of the "Vegetable Farm" project in **The Journal**, the markedly different foray against the evils of drug abuse depends on a series of stories about the life and travails of a group of vegetables, including the influence of an outside non-vegetable, the sinister Mr. Mushroom. Most children quickly recognize him as the pusher.

The idea is to stress societal values — the traps of lying, the joy of true friendship, the shallowness of prejudice, and the helpfulness of the sage parent — for youngsters in Grades 2 and 3.

The interest of the National Film Board in the story characters and story line for film should come as no surprise: The illustrations for the storybook are the highlight and have a cartoon aura about them.

Teenage drinkers

ARF says attack three ways

By Gary Seidler

TORONTO — The Ontario government should consider increasing the legal drinking age to 19, adopt a system of proof-of-age identity cards, and establish a uniform alcohol education program in schools throughout the province.

This three-pronged attack on increasing alcohol problems among young people is suggested in a statement submitted to the provincial government by its agency, the Addiction Research Foundation.

Implementation of these action steps would represent "important advances toward the further development and application of a comprehensive public health-oriented approach to alcohol control measures in Ontario," the ARF statement said.

The Foundation reminded government that liquor laws in Ontario have been gradually and continuously liberalized since 1945 and, by increasing the drinking age, the government would be initiating "the first move in the opposite direction for more than a generation".

While the ARF acknowledges concern over mounting drinking problems experienced by young people since the province lowered the legal drinking age from 21 to 18 in 1971, it points out that this rise must be viewed in the context of overall rising consumption on Ontario.

"There is no doubt that the teenage drinking issue represents one important element in the overall problem. However, it cannot be viewed as a separate or extraordinary development when the society as a whole is confronted with such major increases in per capita consumption and alcohol-related public health damage."

The ARF statement acknowledges that a return to the previous legal drinking age of 21 might well be impractical given that such a move would remove rights previously conferred on large numbers of people.

Consequently, the ARF suggests government raise the legal drinking age to 19, employing a staging process to ensure those who are now legal consumers do not lose this status.

Further, the Foundation said effects of such a change should be studied for two years to facilitate further decisions on whether additional increases in the drinking age were necessary or feasible.

To support its contention that 19 be considered as the new drinking age mark, the Foundation pointed out that most high school students would then not have the opportunity to drink legally.

"It is expected this would at least have a beneficial effect on the secondary educational system particulary in its influence on younger adolescents."

Without effective enforcement, however, raising the drinking age would have little positive effect, the Foundation said.

Government is asked to consider a revised system of proof-of-age cards which would be the only acceptable proof of identity and age.

"Effective application of such a system would help eliminate the black market in proof-of-age documents and make it very difficult for under-age individuals to buy alcoholic beverages."

Pointing out that any recommendations aimed at reversing the present trend in teenage drinking behavior must be considered within the context of an overall attempt to alter society-wide attitudes toward the use of alcohol, the ARF suggests government direct an education campaign to the public concerning drinking legislation as it relates to age and the consequences of breaking laws.

Further, the Foundation suggests a uniform, effective alcohol education program in schools throughout the province.

Raising driving age — a loaded issue

TORONTO — Government officials should think twice before increasing the driving age as a means toward countering problems of drinking and driving by teenagers, the Addiction Research Foundation has cautioned.

An ARF statement, submitted to the Ontario government, suggests raising the driving age might well aggravate rather than relieve mounting accident rates involving young people.

(The legal drinking age in Ontario currently is 16).

The Foundation statement points out that before the drinking age was lowered from 21 to 18, young adults were reasonably experienced drivers before they were significantly involved in "learning to drink".

The lowering of the drinking age narrowed this gap to two years, and says the Foundation, the increase in drunken driving offences in the 16-19 age group appears related to this narrowing.

"If the driving age were raised further, Ontario teenagers would be learning both to drink and drive at the same time.

"Evidence suggests this simultaneous learning of these two key patterns of behavior may be disastrous."

Davis edgy on age hike for drinkers

TORONTO — Ontario's Premier William Davis has ordered a study to determine whether Ontario's drinking age should be raised to 18.

The study, which will also investigate the problem of teenage drinking and driving, will be conducted by the Ontario Youth Secretariat under the leadership of Terry Jones, MPP (Member of Provincial Parliament) for Mississauga North.

Mr. Jones will begin the study immediately with public meetings held across the province to discuss alcohol abuse among youth.

A report of the Youth Secretariat's findings will be submitted to the government by April 1.

In a letter to Toronto's North York Council — which passed a motion last November urging the Ontario government to raise the drinking age — Premier Davis said he attributed drinking by youths to "the general affluence of society combined with a general weakening of parental and other authority".

Premier Davis indicated the government is "taking a serious look at stricter enforcement" of liquor laws, a possibly to issue identification cards for those age 18 and over, and remove licences from establishments "found guilty of serving liquor to minors".

Alcoholic MDs should not be protected

(continued from page 1)

and rejection," Dr Edwards says.

"Illustrations of connivance are many. A surgeon has obviously unsteady hands, but no-one likes to do anything too positive. He is persuaded on bad days to let his registrar take the list.

"A consultant physician is drunk on teaching rounds and is simply regarded as a well-known figure of fun.

"The anaesthetist is too hung-over properly to function, but somehow keeps going on a handful of swallowed chlordiazepoxide . . . "

Dr Edwards claims there should never be cover-up in such situations. If the surgeon is unfit to operate there should be confrontation there and then — not 10 years later. Never in any circumstances should a less than frank reference be written for the sake of a quiet life.

Medical practice and active alcoholism "simply do not go together," the author concludes. It is neither in the patient's interest that the doctor should further jeopardize his career, nor in the interests of society that his patients should be put at risk.

"Alcoholism in the medical profession is a subject which now requires to be brought out into the open with a response which is both kind and rational. The problem does not need to be exaggerated or dramatized. But to go on hiding this business in the shadows is in no one's interest."

Mini-scales tilt for marijuana justice

(continued from page 1)

drug after Jan. 1 will automatically be purged after two years.

There is considerable variance in the response to the new law.

Instead of the vest-pocket-sized portable scales employed by Los Angeles police officers, the Los Angeles Sheriff's Department is equipping its deputies with small metal cans that can measure up to two ounces. Both devices are intended to provide approximate measurements only, with final and precise determinations later in station houses or crime laboratories.

The San Diego police will not use scales or any other device, but will rely on visual estimates of amount, and will follow a general policy of giving the suspect the benefit of the doubt.

Various law enforcement agencies differ as sharply in their views on the future impact of the new regulations.

In Los Angeles, both police and sheriff's department spokesmen predict the liberalized law will require more paperwork by them and will lead to increased use of marijuana.

San Francisco officials do not expect additional paperwork, and believe the law will save money for the state and free police to concentrate on more serious crimes. For a year before the new law went into effect, San Francisco police followed a policy of citing suspects rather than arresting them for simple possession.

In San Diego, a police spokesman noted that for more than five years, simple possession has been treated as a misdemeanor, and he saw no evidence the new law would lead to increased use.

In Sacramento, a representative of the California Judicial Council predicted financial savings because most possession cases now will involve no arrest, no booking, no custody, no bail services and no jury trial, and many of those cited will simply pay the fine rather than appear in court, just as in the case of traffic citations.

Other reactions traversed the liberal-conservative spectrum, ranging from Los Angeles Police Chief Edward M. Davis' prediction that the old statute will be reinstated within two years, to legal action instituted by the National Organization for the Reform of Marijuana Laws to invalidate all penalties for cultivation, possession, or use within the home as an invasion of privacy.

Pill-drunk drivers escaping breath test

LONDON — The number of women who drive while under the influence of soft drugs has reached such a proportion in Britain that the public and police must be made aware of what is happening, claims a family physician.

Dr William Reilly, of Talford, Shropshire, said experience with his own patients has prompted him to write to the *British Medical Journal* about the drugged woman driver.

He made it plain he is not getting at women as such. But, the fact remains, women "do seem to require more prescriptions for tranquillizers than men," he said.

Dr Reilly said recently he had a woman patient who drove through rush hour traffic to reach his office. It turned out that she had a combination of five drugs in her bloodstream.

The woman refused to listen to Dr Reilly's pleas that she not drive and he, in turn, was powerless to stop her.

Dr Reilly said he has another woman patient who was stopped twice in one night by police because of her erratic driving. The second time she was given a breath test for alcohol.

"I can imagine the bewilderment of the law at finding an apparently drunken woman whose breath left the color of the crystals unchanged," Dr Reilly said.

"Yet I doubt if it ever crossed the minds of the policemen that she might have been drugged."

Most policemen in Britain still think of drugs in terms of heroin, cannabis and amphetamines "and a well-dressed woman driving the family car could hardly fit their picture of a drug addict".

Dr Reilly said that his fellow physicians are not blameless. Too often they fail to warn patients they put on drugs that they may experience drowziness or impaired reflexes.

Philosophies and governments tangle

Drugs in B.C.

By Tim Padmore

VANCOUVER — The debut here of two approaches to the problem of drug addiction has been marred by friction between philosophies and between levels of government.

An anecdote illustrates the point.

When British Columbia's human resources minister Norm Levi was pounding constituency pavements in his unsuccessful bid for re-election to the legislature last December, he came up upon an old warehouse with the freshly lettered words "Alternatives Program" on the door.

When Levi, the minister responsible through the Alcohol and Drug Commission of BC for all provincial drug treatment programs, discovered that a federally-funded drug addiction treatment centre had sprouted like a mushroom in his own back yard, he was furious.

It did not help that the Alternatives Program, (see accompanying article) is based on the "addicts can be cured" philosophy as opposed to the one that has prevailed here recently — "you may be able to cure addicts, but in the meantime, offer them methadone to keep them away from crime".

The commission has recently revamped its methadone maintenance program, opening five "store-front" clinics in Vancouver in place of the austere, impersonal program run from the old Narcotics Foundation building. (See accompanying article.)

Today the fires kindled by the clash of governments and philosophies have died down.

Ron Draper, director-general of the Non-Medical Use of Drugs Directorate, sponsor of the Alternative Program, says the province was not informed of the new program because of confusion surrounding administrative reshuffling at the NMUD regional office here last summer.

Draper visited the miffed commission before Christmas to explain the program and says he is anxious to co-ordinate the program with other drug programs in the province.

Program director Ray Cohen, who encountered some initial tentativeness in his dealings with the local hierarchy, says a more comfortable working relationship is developing.

And, of course, the irate Levi is gone, along with the NDP government and the alcohol and drug commission itself.
(See page 1)

In Levi's place is one of the commission's most vocal critics, Bob McClelland, who said in an interview shortly after his cabinet appointment:

"(Governments) have adopted the attitude that the problem is insoluble. I believe it can be solved. I don't have the answers yet, but I intend to find them."

McClelland agrees with Draper, who says BC offers "a relatively small number" of options for drug addicts and that programs which promise addicts a cure must be the government's first priority.

Vancouver treatment program for addicts

Federal centre aims to 'cure'

VANCOUVER — For a heroin addict, cold turkey withdrawal is no worse than a bad case of the flu.

The real agony comes later, when the ex-junkie is trying to stay off drugs while facing overwhelming temptations from friends who are addicts and from his very lifestyle, which has revolved around crime and drugs.

A federally-supported treatment centre which opened its doors here last month is applying powerful behavior modification techniques to help addicts break through that second barrier.

The Alternatives Program, which is receiving $195,000 this year from the Non-Medical Use of Drugs Directorate, hopes to be able to accommodate about 100 addicts and to be able to promise a "cure" to the majority of them.

For the first step in his rehabilitation, the addict will spend 10 days at the centre in the company of 10 "straight" volunteers. They will refuse to discuss crime and drugs; they will try to stimulate new, constructive interests; and some of them will, in the end, become his friends.

"Imagine what would happen if you put a clean-cut adolescent in a room with 10 hardened drug addicts for 10 days. This is just the reverse," said program director Ray Cohen during a tour of the unit.

The next step is an interview with "the panel", a group of three staff members who quiz the addict on his motives for entering the program and his determination to succeed. The tone is deliberately agressive, so the addict is relieved and happy if the panel announces that he has been accepted.

At the heart of the program is a written, legally-binding contract between the client and the centre.

The contract requires the client to appear regularly for counselling sessions, to report his activities to the program staff several times a day at fixed times by telephone, to give up his drug-culture friends and, of course, to stay off drugs. Rewards are provided for keeping to the contract, and penalties are set for breaching it.

The purpose of the contract is to provide re-inforcement for actions that lead him away from drugs as well as to give him incentives to co-operate with other parts of the treatment program.

Terms of the contract are worked out with the addict and in the beginning it may control most of his daily activities.

"The contract is fluid and is constantly changed," said Mr. Cohen. "When the client starts to assume personal responsibility for some aspect of his life, then we knock off that clause.

"The contract begins as a pretty hefty document and it gets smaller and smaller until it's amended to the point where it doesn't exist any more and the client is completely self-responsible."

That may take from six months to two years. Then the former addict is free to pursue his new life, except for periodic follow-up interviews and urinalysis spot checks.

The program has 15 full-time staff members and operates out of a remodelled warehouse with offices and three rooms where clients sleep during the initiation period.

The Vancouver program is similar to one Mr. Cohen set up in Montreal 3½ years ago.

NMUD director general Ron Draper said in a telephone interview the directorate is anxious to broaden treatment options available in Vancouver.

"There are three things we like about the Alternatives Program," he said. "It's drug free... it recognizes drug abuse is a life-style problem... and it makes heavy use of volunteers."

(Follow-up statistics from the Montreal clinic are not available yet, but an indication of its success is that 74.5% of the centre's clients were found to be drug free during one 18-month period.)

In Vancouver the program will have to deal with people with a longer history of drug abuse, a subculture which is more drug-oriented, a different racial balance, and a more critical housing and employment picture, said Mr. Cohen.

Among other adjustments to be made, volunteers must be prepared to "dig deeper," he said.

Contact with volunteers is maintained after the initiation period as the client slowly builds a new circle of friends through them.

Therapy called for in the contract includes counselling and role-playing exercises to teach skills such as how to get through a job interview.

A wrist counter is used to keep track of significant thoughts — drug urges, moments of tension, thoughts of a close friend or spouse, and so on.

Failing to log these thoughts, or failing to phone in on time, might call for a $20 fine, while compliance might be rewarded with a pair of donated concert tickets.

All contracts carry an "honesty clause" which halves penalties if the client owns up to a breach of contract before he is caught.

The main emphasis of the program is on treating heroin addicts, but Mr. Cohen said that as it develops he expects to move into other areas, including treatment of barbiturate and alcohol addiction, training programs for medical and para-medical students, and programs designed for people on probation or parole.

Mr. Draper said he hopes the provincial government will decide to take over the plan, adding that federal funding will end after three years barring unusual circumstances.

Methadone maintenance

Province opens store-front clinics

VANCOUVER — "At that Broadway thing, they ran you through like cattle. You went in from the back alley, because you weren't front door material."

The speaker is Arthur, a 45-year-old drug addict. He is describing Vancouver's methadone maintenance program as it was operated until recently.

"This is much better, very nice," he says with a gesture taking in the comfortable store-front clinic, one of five similar units that have taken over the work of the former clinic, which operated out of the austere Narcotics Addiction Foundation building.

Staff and addict meet at clinic

There has been a corresponding multiplication of staff too, so the clinics can now offer more counselling and some hope for a genuine cure, as well as a more pleasant atmosphere, clinic supervisor Hamilton Thomas told The Journal during a recent interview and tour of the clinic.

"The major emphasis of the program is to decriminalize the addict," said social worker Phil Gray. "There are a lot of people who have been out on the streets since the age of 14 hooking, boosting and breaking and entering to support themselves."

The free methadone replaces illegal heroin currently selling here for around $30 a capsule.

Another result of the increased supervision has been a dramatic decrease in the amount of methadone reaching the streets illegally, Mr. Thomas said.

One problem with the old program was that addicts suspected clinic personnel of collaborating with police narcotics squads.

Ian Waddell, a member of the Alcohol and Drug Commission, which funds the clinics, said the staff at at the store-front clinics are scrupulous about honoring client confidentiality.

Added Mr. Thomas: "This is an attempt to reach the addicts in their own community in an atmosphere more conducive to trust, and to maintain contact."

The clinic, which is staffed by two social workers, a receptionist and a consultant doctor, serves about 75 drug addicts.

In addition to the nearly 400 addicts served by the Vancouver units, there are about 200 more in other parts of BC served by clinics in Coquitlam, Nanaimo, Prince George, Trail, Victoria, Campbell River and Kelowna.

Low- liquor liquor for LCBO?

The potential widespread use of such products as options to alcohol, and their manufacture by other wineries, depends upon the LCBO's acceptance of Carl Jung and the success of the Ontario marketing experiment, according to Barbara Cowan, Health director for the company.

The LCBO Board, which had refused to comment upon the possible inclusion of dealcoholized products before the Act was proclaimed, has yet to make its position known. And, dealcoholized products are one among many wines whose manufacturers are asking for inclusion on liquor stores lists.

Meanwhile, the Ontario Ministry of Health is in the process of establishing information on "alternatives to alcohol" to help combat rising alcohol use in the province. However, it does not know whether it's prepared to publicize information about dealcoholized wines in its educational literature.

Marion Dempsey, project coordinator for the Alcohol Education Program of the Ministry, said government policy prohibits endorsation of one commercial enterprise. In this instance there is only one.

More on the status of non-alcoholic wines and malt beverages will appear next month in The Journal.

Pot - 'a potential social disaster'

An interview on cannabis with Dr Eugene LeBlanc, by Anne MacLennan — (continued from page 1.)

"I'm not saying a person who smokes a cannabis cigarette is doomed to die or that I have any sense of 'Reefer Madness'. I'm not saying we're going to have a race of junkie monsters running around the streets raping and pillaging.

"I'm looking at the global population point of view and analyzing it in terms of an additional insult. In a toxicological sense, a biological system can only absorb a certain number of insults.

"And cannabis is an insult as we know from its tar content, as we know from its drying effects, as we know from its harshness, and as we know from its production of increased heart rate and psychiatric disturbances.

"We have clear evidence from a societal point of view that things — insults — like alcohol, tobacco, progressive air pollution, water pollution, mercury in fish and so on — things which do not produce dramatic and immediate damages — can still produce tremendous health burdens on society.

"And I'm against doing anything which is going to put more pressure on the pressure cooker that society already is."

Meanwhile, society is going to have to realize that the budget for health care has gotten as big as it's going to get. Even the most sophisticated societies have reached the point where they do not have many more dollars to draw on, he said.

"It will have to think very carefully, therefore, about embarking on any kind of social practice that increases health costs unless, and at the same time, it stops something else. Piling one more in without taking cognizance of the existing pressures and without getting rid of one, is going to produce a disaster in the whole social services sector."

While Dr LeBlanc does not think there will be a disorder or disease unique to cannabis, he believes regular widespread use "has tremendous potency to augment some that are already major problems".

"Lung disorders are a major health problem and I think increasing the numbers and types of things smoked cannot help.

"Worse than that, I think we have problems of a psychiatric and neurological type due to various kinds of insults and I cannot help but believe they will be more widespread because of cannabis — just on the basis of the history of pharmacology.

"We don't want to be prisoners of history but I think caution is certainly needed. We are not talking about absolutes. We're talking about changes in incidence of, changes in intensities of . . ."

Dr LeBlanc agreed it's possible for someone to argue: 'I don't smoke, I don't drink, I watch my weight, and the fact that I want to have a joint once in a while so should be acceptable'.

"I can accept that. What I cannot accept is the blind movement towards embracing cannabis as a broad phenomenon on top of the other kinds of health and social dilemmas we have.

"If the decision is made to legalize cannabis, use of the drug will spread. If no compensatory reduction of insults to the health of the general public is made, there will be increased costs in those areas of social services that we now have. The health services particularly. And there is no more money. There'll have to be a decline of service — more than is already under way."

"No reasonable person would say regular, widespread cannabis use is going to improve the health."

Dr LeBlanc agreed that arguments concerning rightness or wrongness of widespread cannabis use are often emotionally loaded and that a great deal of attention is devoted to the drug.

Cannabis is not unique, however, he said.

"New developments are showing that drugs in general are not safe. This is not unique to cannabis. Cannabis just happens to be the beneficiary of these developments. And it is a drug and cannot be exempt."

"For the moment, society is prepared consciously to accept casualties and, indeed, has earmarked money to care for casulaties. Whether that is a good bargain is a moot point. The fact is there is no more money to take care of them.

"We all have a vested interest in any decision on our behalf. Individuals who decide something do not decide for themselves, they make a decision collectively. In effect, they commit society to earmarking money. And there is no more money."

In terms of research, Dr LeBlanc said the area from which people could draw most understanding of the drug's potential effects, is the area which is "most defective".

"If you accept that we are not going to have immediate or drastic effects with cannabis, we are left probably with the kind of classical interested in, which is related to increase in, frequency of, and earlier onset of, things that happen in normal populations.

"For example, cirrhosis occurs anyway and alcohol increases the rate. Lung cancer occurs anyway and smoking increases it.

"So, if you accept that this is where you are going to be looking, then it takes a certain kind of experimentation and that kind of experimentation has not really been adequately appreciated until very recently.

"It involves life's studies or it involves massive numbers and longitudinal studies. And in my view there have been no good studies done in this area in recent years.

"Modern views of toxicology have to be consulted and what you have to look at are detriments in capacities of various types, not changes in background activities. For example, if one wants to see the effects of some kind of disease process on the heart, measuring the person's heart rate when he's lying on a table won't tell you as much as putting him on a treadmill and seeing how fast he can go before the heart does something strange.

"The important thing now though is that there is a tendency towards using more sensitive probes and I think this is going to be the way of the future.

"We are moving on several fronts towards better, more solid, more sophisticated research.

"People have begun to be more sophisticated and to look at drug interactions, chronic effects. They're beginning to look at subsystems. Not just at global effects but at trying to locate cellular effects."

There is also now the massive, if illicit, experiment going on.

"Whenever a drug is released, after all the animal work is done, after all the human control studies are done, the final experiment is always the one the consumers perform. You can't really avoid that final experiment.

"With cannabis, people have been trying to move into the kinds of experiments that would comment ahead of their time on the final experiment. They have done the last page of it rather badly.

"Nevertheless, one day we'll be able to look back over time and come to some conclusions about the drug, in the same way as we have come to some conclusions about alcohol."

"I'm not saying a person who smokes a cannabis cigarette is doomed to die or that I have a sense of 'Reefer Madness."

Alberta toughens driving laws

By Walter Nagel

EDMONTON — The Alberta government has introduced legislation to encourage defensize driving and get more impaired drivers off the roads. The move follows a comprehensive traffic study received in late 1975.

The measures which became effective Jan. 1, are aimed specifically at young drivers — long blamed for a high proportion of accidents — and at those in older age groups who persist in dangerous motoring habits.

A keynote of the new regulations is a special driver review board with the power to suspend, indefinitely, the licence of any offender. As well, the board may preseribe remedial measures such as alcoholism treatment or driver education.

Provincial Solicitor-General Roy Farran, who introduced the new Motor Vehicle Administration Act, told the Legislature: "If all else fails, we must use the strict, as well as the honeyed, word."

However, he said there will be principal emphasis upon the educational approach before definite or indefinite licence suspensions are invoked.

"No amount of tough news laws will do any good unless driver attitudes are changed."

Two years ago Mr. Farran, then minister of telephones and utilities, had his own licence suspended because of a drinking-related infraction, and he was forced to undergo a program of re-education. He said the experience made him a supporter of such sanctions.

Other features of the new Motor Vehicle Administration Act include a halt to the issuance of scooter licences to youngsters of 14 to 16 years of age. Those who now hold such permits may keep them, but the minister said no new licences will be sold to first-time applicants.

People applying for new or renewal licence plates will have to present written proof they have proper insurance coverage on their vehicles. In the past, the applicant merely affirmed such protection had been purchased.

All 16-to-18-year-old drivers will be placed on probation, and risk losing their licences to drive immediately if there is evidence of misbehavior on the road. Provincial officials have noted that teen-age motorists account for a disproportionate number of accidents, injuries and deaths.

Until now, the province has relied upon a demerit system, operated by the highways department and the courts, to suspend and re-license offenders. The new legislation should allow speedier and stricter handling of such cases.

The new driver review board will have power "to prescribe any measure or course of remedial education or treatment (of alcoholism, for example) as a condition "for possession" of a driver licence. It may specify certain terms and conditions, and "take into account the person's accident record, conviction record, driver attitude, driver skill and knowledge, driving disabilities and any other factors it considers relevant."

In 1974, almost 600 persons were killed in traffic accidents within Alberta, and almost 15,000 were injured. Since 1971, collisions have increased almost one-third, although the provincial population has grown by scarcely 10 %.

Almost 6,000 persons have had their driving licences suspended by late 1975, among a provincial population of about 2.5 million. In 1975, there were also more than 700 second-time suspensions, and about 325 suspended for a third time.

The provincial Driver Control Board will have to be strengthened to assume a significant prevention and deterrent role, officials say.

Until now, its spokesmen claimed they were hard pressed to check and interview third-time suspension drivers alone. There has been no possibility of personally discussing bad driving practices with persons suspended for a first, or even a second time.

Out of gas? -- try grain alcohol

GRAIN ALCOHOL should be further researched as a future source of fuel, according to the governor of Nebraska.

Governor James Exon told the Western governors' regional energy policy conference in New Mexico that a plant in Nebraska has been producing "gasahol".

He said it consists of 10% grain alcohol (which can be produced from corn or wheat) and 90% gasoline.

The experimental fuel has been used in state-owned vehicles and is being sold commercially in Holdrege, Neb., said Governor Exon.

A report in The New York Times quoted the governor as saying the price of "gasahol" is about the same as that of gasoline.

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Lack of consistency mars alcohol efforts

DID ANYBODY notice when Ontario's Consumer Affairs Minister Sidney Handleman let float his trial balloon on allowing sale of beer at the ballpark — if and when the San Francisco Giants franchise was shifted to Toronto?

Or when Toronto Metro Parks Commissioner Tommy Thompson urged beer sales at municipal golf courses on the assumption that suds would add to the enjoyment of the game?

Considering the media reaction sparked by Attorney General Roy McMurtry's alarm about drinking drivers and about the spread of teenage drinking, one would have expected at least one little query on behalf of Joe Public . . . like "what exactly is going on here?"

Politics these days are confusing enough without having ministers of the same Cabinet speaking publicly at cross purposes . . . or could it be that the ministers don't realize they are in conflict?

It's true that sipping on paper-cup beer as the sixth inning winds down into the seventh doesn't sound like such an insidious social threat — not when we think about it in isolation.

But the point is, we can't think about it in isolation.

The peddling of beer at ballparks or golf links is part of the same continuum of behavior that repels us so in the guise of the drinking driver or the alcoholic teenager.

The risk symbolized by beer in the ballpark is not that it might incite unruly crowds or riots in the bleachers, but that it just strengthens the growing belief that without booze you can't enjoy yourself.

We make alcohol an indispensible part of every social function and then wince when it is regurgitated. But we can't have one without the other.

This is a point which seems to escape most governments and will continue to do so until legislators adopt clear-cut policies designed to reduce overall, per capita consumption . . . not just attack the most visible violator, but reduce the amount of drinking overall.

If this sounds like a reasonable policy then government should say so clearly and unequivocally, and it should act in a concerted, consistent fashion.

That means accepting the probability that the more available we make alcohol, and the more we endorse its use, the more we can expect to suffer the consequences of abuse.

Increasing the sanctions against drinking drivers and teenagers, while at the same time encouraging people to drink more freely at the ballpark, the golf course, or the racetrack, makes no sense.

The bitter truth is that we can't have it both ways, and government ought to emphasize this fact by its own actions.

—MK

A reasoned approach

AN ADDICTION Research Foundation scientist has entered the cannabis fray with some convincing arguments to suggest we may be moving too far, too quickly, toward legalization of the drug.

In an interview with **The Journal** (Page 1), Dr Eugene LeBlanc introduces a reasoned approach to an issue so fraught with emotion that it is often difficult to see beyond that emotion.

Dr LeBlanc presents a strong case that widespread availability of the drug would surely lead to increased consumption and related health problems and says it could be the straw that breaks the camel's back in testing further the already strained health resources needed to sweep up society's casualties.

From a societal point of view, he says, "insults" like alcohol, tobacco, air and water pollution, mercury in fish, and so on, do not produce dramatic and immediate damage but still produce a tremendous health burden on society.

Certainly cannabis does not produce immediate, dramatic negative effects — we'd have seen them by now. But, increasingly it seems there could develop a significant cost to the health system if enough people used the drug long enough, often enough, and heavily enough.

This argument of course, must be weighed against the one which says that keeping cannabis illegal allows, given relatively widespread illicit use, for a far more damaging disease — the social disease of having a criminal record.

But, for Dr LeBlanc at least, cannabis does not — not yet anyway — have the clean bill of health that would support making it an inherent part of all our lives.

Quite apart from one's personal point of view, it is encouraging to see this kind of global approach by a professional in the field. He isn't warning of 'Reefer Madness' and he isn't saying society owes it to itself to "turn on" with cannabis.

It is this sort of approach that is so necessary to assist the public to understand the broader issues which underline the continuing cannabis controversy.

— GS

"Wow! Drink this dealcoholized booze at a business luncheon and you end up talking business."

Letters to the Editor

More letters — page 12

"Intredict list"

Sir:

One day last August, Ted Bouvier was present in JP court as instructed by an appearance notice.

For his trouble, he was fined a total of $175 or 100 days in jail on two charges of interdict consuming liquor.

Why? He had a drink.

Not for causing a disturbance, fighting, failing to leave a bar when asked, illegal possession of alcohol or impaired driving.

All of these actions are against the law and anyone (almost) can be prosecuted in a court of law for having committed these and other offences of the Canadian Criminal Code and Territorial Ordinances.

Mr. Bouvier is a special person under the law. He is on the "interdict list".

You have to be special to be convicted of interdict drinking:

First you must have what some people consider a "drinking problem".

Secondly you have to be placed, voluntarily or otherwise, on the "interdict list" supposedly to control your drinking. (Since when has the threat of jail controlled drinking?)

Thirdly you must have a drink.

Usually because interdicts have a drinking problem they have more than one drink.

However to break the law, when you're interdicted, just one drink will do, thanks.

Don't break any of the laws most people observe, just have one drink like your neighbour and it's into the slammer for you.

There is one other attribute which increases your chance of being convicted of interdict drinking, or making "the list". It helps to be native.

In Hay River seven of the 10 interdicts are native persons. The Hay River population is considered to be over 50% white.

Sixty-three people are on the interdict list in the entire Northwest Territories.

One last thought.

When was the last time an impaired driver was placed on the interdict list or are they not problem drinkers?

Chris Brodeur
Editor, The Hub
Hay River
Northwest Territories
(This letter is an edited version of an editorial published by Mr. Brodeur in The Hub.)

Concern over poppies

Sir:

Your recent article entitled "Great Scarlet Poppy Poses New Threat" causes me and others who have been deeply involved in the opium issue serious concern.

The article which was not up to the usual high standards of your publication did a gross disservice to the field by being not only superficial and one-sided but also by inappropriately feeding the hysteria about drug abuse at a time when we have made an extraordinary effort to emphasize accuracy, facts, and a rational, and unemotional approach to the drug problem.

Domestic cultivation of *Papaver bracteatum* in the United States appears to have a number of major advantages. At a time when supplies of opium for the legitimate needs for medicinal codeine are erratic and subject to the vagaries of international politics, unpredictable weather conditions, and primitive cultivation methods, self-sufficiency through domestic cultivations has enormous appeal. The potential for diversion of the *Papaver bracteatum* or its products can hardly be considered a serious

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Backgrounder

IN THE last year, close to 200 alcohol and drug treatment counsellors in the Province of British Columbia have gone through a series of interviews and tests geared at defining who they are and what they ought to be doing.

The process, call it certification or credentialling, might at first glance appear to have been thought up by some malevolent paper chaser in personnel. The regimentation reflected by such terminology as Trainee Group III, or Trained Worker Group 1, seems an incongruous way of describing the functions of a streetworker who must rely more on his wits and intuition than on any treatment guidebook.

Yet to thousands of counsellors and drug abuse treatment administrators in North America, the need to develop an effective credentialling mechanism, and with it a more universally acceptable training system for counsellors, is anything but bureaucratic makework.

It is a means of assuring that treatment personnel are what they seem to be — competent to guide their patient-clients through some part of the treatment/rehabilitative cycle.

Not everyone is convinced the motivation behind credentialling is all that pure.

At a recent meeting of the ADPA, where credentialling and certification were major concerns, there was no absence of scepticism about what some saw as a paper chase.

As one irate counsellor charged: "Credentialism is an academic trip with all its symbols and crap.

"Even if we get to the point of defining competencies and tasks and experiences, all we're doing is essentially buying our way into certain academic institutions."

The fact is that what many people refer to as a credential, looks, smells, and feels like an academic diploma, and by its very nature predisposes against the counsellor whose dues were paid on the street and not in the classroom.

Some, such as Don Ottenberg of Eagleville, suggest the effort now being expended on developing credentialling criteria might be better used by channelling promising paraprofessional candidates into academic training environments . . . so long as the schools themselves are willing to give appropriate credit to life experience.

"If the schools that are able to give degrees are willing to credit this (life experience), it's far wiser to have academic credentials rather than certificates which might only lock paraprofessionals into the lower part of the totem pole."

Says Mr. Ottenberg: "I really doubt that the field of human services in general is really going to see a certificate from this school or that institution as equivalent to a master's degree."

Well, maybe not. But in British Columbia, and Nevada (**The Journal,** January) where certification processes have taken some definable form — well ahead of most other jurisdictions in North America — the academic degree is but one component in the makeup of a certified counsellor, and the emphasis of the evolving certification process is to prevent the qualified, but not academically-trained worker, from being regulated out of existence.

The British Columbia manual for staff accreditation, put out by the Alcohol and Drug Commission, puts it this way:

"It is unreasonable to expect, and undesirable to have, all treatment programs for drug abusers staffed by professionals from the various helping disciplines. Traditionally in this field as in other areas of human distress, significant contributions have been made by concerned, personally-competent people, who . . . do not possess membership in any of the professional guilds.

"It is also true, however, that inestimable damage has been done by concerned people whose only qualification has been good intentions and a sentimental need to help."

The debate about who should treat whom usually degenerates to nasty squabbling between professionals and non professionals, and it is a "tiresome debate" says the BC manual.

It is also destructive in that it is "usually a thinly-disguised conflict between groups who are trying to protect their status on the one hand, or trying to get a piece of the action on the other".

The real issue, once the squabbling is cleared away is simply this: Is their any advantage of a trained helping person over an untrained helping person? The answer, says the BC manual is "an unequivocal yes".

Dr Al Connally, director of staff training for the BC Alcohol and Drug Commission is pleased about the reception counsellors (non-academic as well as degreed individuals) have given to the credentialling initiatives. Of course, they didn't really have as much choice about enduring the certification process as they might have. "I suppose there is a veiled threat," Connally admits.

In the second of a series of Backgrounders, Milan Korcok, Contributing Editor of **The Journal** *examines the pros and cons of credentialling of alcohol and drug counsellors, a high priority item for those involved in providing treatment.*

One of the ground rules for program funding is that all relevant staff go through the accreditation process.

But many of the paraprofessionals who have been working effectively for some time, think it perfectly appropriate that they be given documented credit for their level of expertise.

Mr. Connally is quick to point out that the process is not yet inscribed in granite. It is in its early stage of development and experience will dictate its evolution. But it is a start.

The grid consists of the following cateories: Trainee Level I through III; Trained Worker; Supervisor; Program Director.

Trainee Level I (minimum age 25 except for youth-oriented programs) demands a "capacity for empathy, positive regard for others, honesty, self awareness, openness and enthusiasm, normal intelligence and the ability to read and write."

In terms of life experience a candidate for Trainee Level I must have been free of drug dependence for at least two years prior to application and must have a history of social stability for two years.

The trainee's first year in any program is probationary. He must be willing to take a 30-day training course (now being developed by the training division of the commission) and he must be willing to undertake reading assignments and other training functions.

As the trainee passes through the three levels, the demands and expectations naturally go up.

The trained worker category demands successful completion of the trainee program, or a Bachelor of Social Work degree with two years experience, or a Master of Social Work degree, or five years stable recovery period and/or employed, full-time status as a counsellor for at least three years.

At the top of the pyramid is the program director, who may climb to this level via the "inside" trained worker route (which doesn't necessarily demand academic credentials such as B.S.W. or M.S.W. though having the degrees does cut down on the experiential time required).

If someone seeks entry into the system from outside, at the program director level, he will have to document 10 years of stable recovery from dependence, a history of personal and social stability, a good supervisory and administrative record, and thorough knowledge of the latest methods of treatment.

Individuals with an M.S.W. and two years supervisory experience may apply at this level.

The classification panel in BC (still in a state of evolution) is to include two members of the training division of the commission, a representative of the board of the employing agency, one staff member selected by the staff, and one community agency representative. The task of this group is to classify the personnel and assess their experiential records.

The makeup of this panel is similar to the one devised in the State of Nevada in that it represents the candidate's peers as well as the regulating agency and the employer.

There are some variations between the two jurisdictions in respect to criteria used to slot workers into certain categories, as there are between them and the Littlejohn study group — commissioned by NIAAA to recommend a system of standards for the credentialling and training of alcohol treatment counsellors.

But there are more similarities than there are differences, and the point is that the initial steps are being taken . . . first in individual jurisdictions, then possibly on a wider scale.

If the credentialling process is to have any lasting value it will have to achieve some universal credibility. A succession of parochial "diplomas" isn't going to do much for the recognition of "the new profession" as Littlejohn calls the emerging counsellor.

Because the jurisdiction for credentialling ultimately lies with states and provinces, it is unlikely the field will ever achieve one universal, national credentialling grid in which Trainee Level I in BC means the same as say, in Ontario and New York.

Perhaps national standards can only refer to minimal, or core competencies. If enough states and provinces start using similar mechanisms as well as language, it may not be necessary to have Trainee III in British Columbia equate Trainee III in Florida.

But at least a counsellor job candidate could document his level of competency and assure a prospective employer that he does have the capability of delivering what his certificate says he can deliver.

By Wayne Howell

Literary sleuths are forever discovering lost fragments of major and minor classics. I have it on good authority . . . well relatively good authority . . . . that what follows is an extract from a chapter of Jonathan Swift's 'Gulliver's Travels', a chapter that inexplicably did not appear in the 1726 version:

Having departed from the Lilliputian shores and the kingdom of the Brobdingnags, I voyaged hence to the land of the Homeostatisticians. I was received with uniform civility by these hospitable beings who, unlike my previous hosts, were of a stature more or less equivalent to man except they tended to be short, not unlike the pygmy races, and they possessed craniums of truly remarkable dimensions; these, I was informed, were a natural evolutionary consequence of the constant calibrating, computing, and cost-accounting, that was so much a part of Homeostatic culture.

The Homeostatisticans abided in fine towns and cities and they seemed a uniformly industrious lot, applying themselves to their various tasks with admirable vigor. That is not to say asceticism was a way of life, for they also pleasured themselves in the traditional manners, partaking of the joys of the groaning board, the flagon, and the Virginian weed. But the most striking thing to the casual observer was the degree of moderation with which they pursued these singular endeavors. My natural curiosity aroused, I made several inquiries of my hosts to ascertain how this most admirable state of affairs had come about.

They most graciously consented to answer such pertinent questions as I should entertain and thus I discovered that by Statute of Law, all Homeostatisticians were free to self-destruct in any manner of their choosing although for all practical purposes most citizens who chose to self-destruct did so in only three ways: By eating too much. By drinking too much. By smoking too much.

Each year, I learned, every citizen was awarded as a matter of right 100 self-destruct coupons to be spent in any manner he saw fit. One hundred self-destruct coupons, for instance, entitled a citizen to purchase 16.5 lbs. of extra sucrose per year, giving him the equivalent of 500 extra empty

(Continued on page 12)

Alcoholism treatment fits addicts

LACHLAN MacQUARRIE reports from The Pan Pacific Rehabilitation conference, Singapore

ESTABLISHED METHODS of treating alcoholism can be taken as models for the treatment of drug dependents, according to Dr Rudolph Mader of Austria.

Dr Mader, Director of the Anton Proksch Institute in Vienna, described experiences at his Institute which have "demonstrated that a methodically worked out treatment model for alcoholics can also be employed with few modifications in the case of drug dependent patients".

"The basic therapeutic principles and methods in treating alcoholics are generally valid as well for drug dependents", Dr Mader said.

Among common factors in treatment are understanding of the influence of social factors and the importance of absolute abstention, he noted.

Methods such as group treatment, family involvement, social work and psychological services, and long term after care are valid in treating both alcohol and drug dependents.

In both cases too, the functioning of a therapeutic community involving help and assistance of former patients is important, he said.

In his address, *The European Approach in the Treatment and Rehabilitation of Alcoholics and Drug Dependents*, Dr Mader said these conclusions had important implications for countries of Europe where, in terms of numbers of patients involved, alcoholism is by far the more prominent problem.

He felt also that programs related to treatment of alcohol dependence offered more reliable models.

"The most effective therapy for dependency diseases, will be a long term and ambulant one where a patient can be helped in a variety of ways to exist under normal reality conditions and correct his abnormal dependency step by step",

Dr Mader suggested another feature common to both alcohol and drug rehabilitation was the limited success of classic therapy methods.

Volunteers: They're a direct stimulus to local participation and involvement

A PRIVATE foundation in the Philippines has harnessed traditional forms of volunteerism, dating back to pre-Spanish times, in the prevention and control of present day problems of drug abuse.

Mrs. Concepcion Martelino, coordinator and treasurer of the Narcotics Foundation of the Philippines, stressed the importance of utilizing indigenous cultural patterns and familiar social institutions — in this case the "bayanihan", a traditional group of people in the Philippine community — to help one another to achieve a common cause.

Organized and coordinated volunteerism in the Philippines, she said, has been used to augment and support government efforts. And volunteers may find themselves involved in one of five major areas of activity — control and law enforcement; preventive and community education; treatment and rehabilitation; direct professional services; and fund raising.

Mrs. Martelino acknowledged that to some extent the use of volunteers in drug programs has been necessary because of shortages of doctors, nurses, social workers, teachers and other professionals.

But she claimed this has also been beneficial in that it has been a direct stimulus to local participation and involvement. Moreover, she said, because of manpower shortages, volunteers know they are needed and perform valuable roles.

Mrs. Martelino said a significant factor in the program is the general policy of the Philippine Government to create an atmosphere conducive to participation by volunteers in a variety of developmental activities as an integral part of nation building.

Education trust needed in national campaigns

INTENSIVE CAMPAIGNS to control illegal traffic, to regulate the availability of dangerous drugs, and to impose severe penalties on traffickers, are not enough in national programs to eliminate drug abuse.

Such programs will likely fail unless they are supplemented by an integrated approach to education and prevention, according to a Philippines expert.

Aurora S. Cudal told the conference the initial response in most countries of the world, when faced by a growing drug abuse situation, was to focus narrowly on drugs as the problem.

Mrs Cudal is chief, Preventive Education and Information Division of the Dangerous Drugs Board of the Philippines.

These efforts sometimes succeeded in achieving control of heroin, morphine and other opium derivatives, Mrs. Cudal said, but there was usually a change in the pattern of drug abuse with people turning to tranquillizers, analgesics, stimulants and depressants.

In addition, there were growing problems of alcoholism, criminality and other anti-social behavior.

Thus the Philippines has planned "an intensive program which seeks to promote inter-disciplinary cooperation and multi-agency coordination of efforts directed towards youth development as well as community development".

This program, Mrs. Cudal said, is not narrowly confined to the dissemination of drug abuse prevention information, but "is more broadly directed towards the development of social consciousness and a sense of responsibility among the youth, the promotion of parental recognition and acceptance of their role in maintaining a wholesome family environment, and the development and implementation of social action programs in the community".

High risk environment

Hong Kong drug plan mobilizes community

LACHLAN MacQuarrie, **The Journal**'s Hong Kong correspondent, whose reports from the Pan Pacific Rehabilitation Congress in Singapore appear on this page, was himself an invited speaker at the congress.

Hong Kong society, which Mr MacQuarrie knows well, is one in which drug abuse and drug trafficking are a familiar part of the environment and thus, one in which young people grow up at particular risk.

In his address, Mr MacQuarrie described his experiences as chairman of a six-month campaign, 'Keep Hong Kong Drug Free'.

The campaign which Mr. MacQuarrie led was aimed at mobilizing the outreach capacity of social service agencies and neighborhood organizations in a community-wide program of education and prevention.

To **The Journal**, Mr. MacQuarrie writes: "The campaign was an attempt to penetrate more deeply into the community than had previously been possible, and to supplement existing programs of treatment, rehabilitation and control by a vigorous community development approach to make members of the public, and especially the young, better informed and less apathetic about Hong Kong's drug problem and more aware of the things they could do to help.

Lachlan MacQuarrie

"It had been recognized this kind of approach was particularly needed in a society like Hong Kong where young people grow up at risk.

"The campaign was divided into three stages with the first stage concentrating on the participating community organizations themselves. In this part of the campaign, seminars and workshops were held to familiarize members of these agencies with the Hong Kong drug situation and to plan with them for the activities of stage two.

"The second stage was the main outreach portion of the campaign. Activities were organized and coordinated on a district or neighborhood basis.

"The third stage took the form of large public meetings held towards the end of the campaign.

"More than 70 community organizations participated, and made the campaign a major theme of their work during the six month period. Most popular among the approximately 300 various outreach activities held were open forums, seminars for youth groups, visits to treatment and rehabilitation centres, film shows, poster competitions, quiz competitions, carnivals, plays, variety shows, mobile exhibitions and radio and television programmes.

"There was a high level of community involvement and public interest was achieved on a budget of only HK$69,000 (about $14,000). This favorable cost/benefit ratio was made possible by the local district participation which resulted from the community development approach utilized.

"Another unique characteristic of the campaign was the most important part made by a hard working group of former addicts whose practical and down-to-earth contributions ensured that the campaign came across to the public in a vital and important way."

Synanon's message travels East

SYNANON CONTAINS a wealth of features invaluable in establishing treatment environments for alcohol and drug dependents, according to Dr M Mahadevan of Ipoh, Malaysia.

Dr Mahadevan, founder and consultant psychiatrist at the Pusat Pertolongan (Help Centre) in Ipoh, told the conference that many hospitals, clinics and community projects in South East Asia have adopted variations of the Synanon therapeutic community approach.

He said his own therapeutic community project is one of several in Asia which has received both direct and indirect benefit from Synanon.

The Help Centre was started in 1970 in response to a growing problem of drug abuse in Malaysia. In the last national survey of drug abuse incidence, in 1973, there were more than 12,000 people dependent mostly on heroin, morphine, opium and cannabis.

The language and cultural diversity of Malaysia has presented interesting challenges for the centre's treatment and rehabilitation staff.

Of a Malaysian population of 12 million, 47% are Malays, 34% are Chinese and about 9% are Indian. This diversity is reflected in the 400 residents of the Help Centre — 250 are Chinese, 84 are Malay, 51 are Indian, and 15 Eurasian.

Main languages used in Malaysia are Malay, various Chinese dialects, and English.

Dr Mahadevan described the religious diversity in the Help Centre and said religion — Muslim, Hindu and Buddhist — plays a centrally important part. The basic philosophy, he said, is "the restoration of faith in the drug dependents themselves and in religion".

"It is not material values and medications which will help our patients. They must have spiritual uplift to encourage them to seek the right path of life."

In giving credit to Synanon for assistance to the Help Centre, Dr Mahadevan suggested other Asian countries and agencies might explore similar benefits.

Columbo Plan countries tightening drug laws

THE SOCIAL and economic effects of drug abuse are now discernable and causing "considerable alarm" in Asian countries, according to Plo Abarro, Drug Adviser to the Colombo Plan Bureau.

He said many developing countries of the Colombo Plan Region have traditionally believed drug abuse was a problem peculiar to Western society and were therefore not greatly concerned about it.

Now, however, the trend in Asian countries is away from opium use and towards use of heroin, synthetic drugs and, in some countries, alcohol, he said in an address, *The Changing Pattern of Drug Abuse in South East Asia*.

This, he said, is leading to the development of "many national programs to eliminate the causes and ameliorate the effects of drug abuse".

Describing some of the characteristics these national programs have in common, Mr Abarro said the trend in Asian countries is to setting up a central administration to provide overall direction and coordination at a high level for addiction programs.

Also, most Asian countries are enacting increasingly stringent enforcement programs with severe penalties for offenders. The death penalty for trafficking is becoming a common characteristic of these programs, he said.

There is also a trend to setting up compulsory treatment and rehabilitation programs.

The Colombo Plan, which includes 24 countries of South East Asia, as well as Canada, Britain, and the United States, began its Drug Advisory Program in 1973 to assist countries in developing treatment, rehabilitation, and control plans.

Cars and bars in Brussels

Alcohol caused 8.8% of fatal road accidents in Belgium in 1972. The same year, 10,372 blood tests were administered with 90% of drivers showing a BAL above 0.08%. Driving drivers were involved in 8,980 accidents with a casualty list of 65 drivers, 49 passengers and 24 pedestrians killed. Seriously injured numbered 1,593, of whom 303 died within a month of the accident.

Teachers scolded

FIJI — Teacher arriving at school with hangovers, red eyes and shaky legs are worrying the Fiji Teachers' Union. The union president, Krishna Datt, says pupils and colleagues are quick to notice signs of a hangover, and a small number of teachers need cautioning about their drinking habits.

Writing in the *Teachers' Journal*, Mr Datt says teachers work under great strain and often have job frustrations. But they can release their tensions through sport and discuss their problems with other teachers over coffee or tea instead of liquor, he suggests.

Smoking habits

Doctors and spouses disagree on tobacco

By P. F. McCarthy

AUCKLAND, NZ — New Zealand doctors are steadily kicking the tobacco habit, but the general population — including doctors' wives — seems less impressed by evidence of smoking hazards.

In a country where 40% of men and 33% of women smoke cigarettes, almost 70% of doctors are non-smokers.

The proportion of cigarette-smoking doctors has dropped in nine years from 39% to 21%. Among women doctors, smokers dwindled from 30% to 13% — but half of the remainder are in the "high-risk" group using more than 20 cigarettes a day.

Interestingly, 30% of doctors' wives still smoke, many heavily. But smoking is a habit among only 18% of the wives of non-smoking doctors, whereas 50% of the wives of cigarette-smoking doctors are themselves smokers.

A 1968 study placed New Zealand fifth in tobacco consumption (behind Canada, the United States, Holland and Denmark). Women of the Maori race, New Zealand's native population, have the world's highest female lung-cancer rate — a distinction attributed to their history of heavy smoking.

The Health Department estimated smoking-induced diseases in 1970 killed more than 8,000 New Zealanders — more than one death in three. Lung cancer caused nearly 10% of these deaths.

Since 1974, cigarette packets have carried a warning and cigarette companies have voluntarily scaled down advertising. (Television and radio advertising was stopped in 1964.)

But the effect on consumption has been hardly noticeable. In 1974, the first year of the warning notice on cigarette packets, the three million New Zealanders smoked an average of 2.3 kilograms of tobacco per person, only slightly less than in the previous year.

The Cancer Society has estimated 60% of children begin experimenting with cigarettes by the age of seven years and up to 70% are smoking by the time they are 12 — but the proportion drops remarkably to a hard-core 10% - 15% in the years between 14 and 16 (the minimum legal age for buying cigarettes).

Around the World

Saki anyone?

Forty million Japanese drink alcohol, 6,500,000 drink too much, and one million need urgent medial treatment, according to an official estimate. Public drunkenness is not an offence in Japan.

France slows down

Though France is still near the top as far as per capita alcohol consumption is concerned, the amount of absolute alcohol each French person drank went down from 27 litres in 1969 to 23 litres in 1970, according to the British Journal of Addiction.

Record breaker

West Germans drank 588 glasses of beer, 34 bottles of wine and 11 bottles of brandy each in 1973. These were the highest alcohol consumption figures since records were first kept in 1888.

Popular pubs

Pub crawling and restaurant skipping are the most popular leisure activities in South Yorkshire, England, a survey has revealed. A report on recreational past-times showed that more people went to public houses for an evening's entertainment than took part in any other type of leisure activity.

Drunks driving

A record 80,000 drunk driving offences were committed in England and Wales in 1975, according to estimates of the Christian Economic and Social Research Foundation. The Foundation attributed the relatively low figure of 65,000 drunk driving offences in 1974 to a gasoline shortage. Offences were also low in 1955 and 1956 when the Suez crisis severely reduced energy supplies.

. . . And the beat goes on

South Korea's most popular disc jockey Lee Jang Hi and singer Kim Chu Ja were among 700 arrested in December on marijuana charges. South Korea's latest campaign against marijuana users has also resulted in warrants against seven other celebrities. Under law, possession of marijuana is punishable by up to 15 years in prison. Selling can also draw a stiff sentence.

Drug education

A new drug education program in the Philippines has sparked interest throughout Asia. The program, known as the Integrated Plan of Action is designed to develop a sense of social consciousness and responsibility among youth and to integreate drug abuse prevention concepts into the educational system.

Family habits

The average British family spent 8.4% of its budget on smoking and drinking in 1974 — more than is spent on fuel, light and power combined. While spending on alcohol increased that year, money spent on smoking decreased.

Howell's Homeostatistician travels

(continued from page 9)
calories per day, an amount sufficient to maintain his body weight at 30 lbs. over his recommended weight, an amount sufficient to shorten his life-span by a factor of 25% — their statistics in these matters being roughly equivalent to ours.

Alternatively, 100 self-destruct coupons entitled a citizen to purchase 22.8 gallons of absolute alcohol per annum, an amount sufficient to maintain a daily consumption of at least six ozs, an amount sufficient significantly to increase morbidity and mortality from causes too various to mention. Alternatively, 100 self-destruct coupons entitled a citizen to purchase 20.5 lbs. of tobacco per annum, an amount sufficient to allow the consumption of 30 cigarettes per day, an amount sufficient to decrease the average age of death by 19 years.

This system of regulated self-indulgence was as flexible as it was ingenious. Some Homeostatisticians chose to expend all self-destruct points on one excess alone — they ate too much. Others chose to eat and drink too much. Others chose to drink and smoke too much. Still others chose to smoke and eat too much. Indeed, many ate, drank, and smoked too much but, of course, only having 100 total points to squander, their excesses within each delineated area were somewhat limited although the total effect remained the same.

Now although this was all most ingenious, it did not in itself account for the admirable state of moderation I had observed in the citizenry and I was therefore disposed to make further inquiries of my hosts.

It was thus I learned that while all citizens were entitled to treatment at state expense for illness, they were not entitled to treatment for illness brought about by self-destructive behavior — unless they had acquired self-destruct credit points which they earned over the years by not completely squandering their yearly allotment.

What a wonderful balance thus ensued! Citizens who did not choose to self-destruct at all had treatment entitlement for any and all illnesses, including of course illnesses usually brought about by self-destructive behavior but known to occur in persons of the most abstemious life-style from time to time. Contrariwise, minor self-destructors usually had enough credit points to see them through a minor crisis such as an alcohol induced stomach ailment or a tobacco-induced bronchial ailment.

But persons who squandered their 100 points each year had no treatment rights whatsoever for self-destructive diseases although like everyone else they were entitled to free treatment for non self-destruct diseases that were no fault of their own.

They could, of course, obtain treatment for self-destruct diseases — but they had to pay what the treatment was actually worth out of their own pockets. This system, my hosts explained, had a most salutory effect upon the manners, morals, and habits of the community at large.

You can imagine, dear reader, how much I was appalled by this heartless scheme — not because of its efficacy which I had to admire — but because of the philosophy underlying it. What seemed most reprehensible was that the system implied that the individual should be in some manner responsible for his own behavior and accountable for his own actions and that this approach was contrary to all modern sociological and psychological theory and a good deal of political theory as well.

"Suppose," I said to the Homeostatisticians, "a man spends all his self-destruct points on alcohol or some other noxious substance; he could be doing this because of socio-psychological factors — parental models or peer group pressures; because of socio-economic factors — physical isolation, hopeless economic circumstances; or because of socio-political factors — the anomie or weltschmerz of his age and times." This they failed to comprehend and so I continued.

"A man," I said, "might spend all his self-destruct points on extra sucrose because of physiological factors — excess body fat cells acquired as a neonate for instance — in addition to the factors heretofore enunciated." This seemed to puzzle them even more and so I continued.

"A man," I said, "might spend all his self-destruct points on tobacco because of inadequate oral stimulation as a suckling babe, in addition to all the aforementioned factors. Would it be fair to deny such persons free aid and succor for the results of their excesses when the excesses were no fault of their own?"

"Then how do you handle these persons when they come to grief as they invariably must?" they responded.

"Why we tell them they must cease and desist for their own good; we tell them to curb their excesses by an act of personal will," I said.

There followed, dear reader, a most disagreeable scene. My hosts shrieked, they roared, they could not contain their mirth. "Paradox! Paradox!", they cried, falling into each other's arms and carrying on in a most undignified manner, not unlike the despicable Yahoos I had encountered in the land of the Houyhnhnms.

"But you just finished explaining how your science says they lack all free will," they said. "If they don't have free will when they start self-destructing, why do they suddenly have free will when it comes time to stop?"

"Well some of them do and some of them don't," I started to explain, only to be interrupted by another outburst of uncontrolled levity.

"What do you do with the ones that don't?", they asked. "In your society does the public pay for a new liver for a self-destructor whose old one has broken down? It is a very expensive procedure you know."

I had to confess that we had not the means nor the wherewithal to perform such a trick at present although we did, on occasion, put new hearts — at great expense — into persons who had destroyed their originals by self-destructive behavior.

This seemed to amuse them and so I hastened to explain. I informed them that in our society, believing as we did in egalitarianism, a poor man had just as much right to self-destruct as a rich man. That was why, for instance, we put an extra tax on champagne but kept the price of beer within the reach of the working man. This seemed to amuse them even more and there was much giggling, nudging of ribs, and rolling of eyes. It was most discomforting; I despaired of meaningful discourse with these strange folk and took my leave of them forthwith.

(Wayne Howell is an Ottawa physician and freelance writer.)

More Letters...

(continued from page 8)

concern in light of the exceptional record of the pharmaceutical industry in maintaining absolute and unbroken security in the manufacture of narcotic preparations in the past. Anyone currently wanting to cultivate *Papaver bracteatum* can do so now, with the seeds being readily available from Iran. The idea that domestic commercial cultivation would lead to diversion is absurd when the plant is so readily available from other sources.

Similarly it is suggested thebaine extracted from *Papaver bracteatum* might be diverted so that it could be converted into a variety of powerful new addicting substances. In fact this option already exists for anyone who has the sophisticated chemical knowledge necessary to make these conversions. Thebaine can be readily obtained in the Middle East and could be converted overseas or here in the United States right now if it was felt by traffickers that it offered them any real advantages. Whether or not *Papaver bracteatum* is grown in the United States for pharmaceutical purposes is absolutely irrelevant to whether thebaine is available to the illicit market.

While it is true that thebaine can be converted into series of highly potent and addictive substances, the process is far from simple, being a quantum leap from the crude knowledge required to convert morphine base into heroin. A sophisticated pharmaceutical chemist could carry out these conversions, but someone of this degree of knowledge and skill could also make innumerable other abusable drugs including the nearly 4,000 meperidine related compounds which could be made starting with basic ingredients that can be purchased legally from any chemical supply company. It is almost inconceivable that such a person would then bother with an illegal organic substance such as thebaine. In addition there is very little evidence that unless there was suddenly a drastic reduction in the availability of heroin in this country which seem almost inconceivable at the present time, any new illicitly manufactured substances would be of much appeal on the street.

In light of the facts the concern about the creation of a "new drug abuse problem" growing out of the domestic cultivation of *Papaver bracteatum* seem illogical, and reflects a basic ignorance about the facts that seems to exist in many people's minds. I am only sorry that your article by repeating the same familiar misconceptions has added to the problem, and I hope you will make an effort to set the record straight and provide in the future a more factual presentation of the issue.

Peter R. Bourne, M.D.
Consultant, Drug Abuse Council, Inc.
Formerly, Assistant Director
White House Special Action
Office for Drug Abuse
Prevention
Washington, D.C.

DWI laws

Sir:

I read the calls for more enforcement of DWI laws and harsher punishment for drunks with interest. (December).

First, it should be noted that what little research has been done on the effectiveness of penalties in the United States and Europe indicates that harsh penalties are no more effective — and probably less effective — than lesser penalties. I will be happy to send you the bibliographic references for that statement.

As a matter of fact, the State of New Jersey has the harshest penalties in the United States; i.e., two-year mandatory revocation and $200 fine for the first offence and mandatory 90 days in jail and 10 years for the second offence, and also one of the lowest DWI enforcement rates in the United States. It can be expected that if the penalties are made stiffer in Canada, the enforcement rate will go down and those who are arrested will be more likely to plead 'not guilty', thereby increasing the burden on the courts.

Richard Zylman
Associate Research Professor
Center of Alcohol Studies
Rutgers University
New Brunswick, N.J. 08903

'Misquote'

Sir:

I was misquoted in your December 1 article on the pregnant alcoholic (pg. 7). I never prescribe Antabuse for pregnant women. I have no evidence that it harms the fetus, however the potential seems great since the drug works by inhibiting enzymes needed to metabolize acetaldehyde and norepinephrine.

My experience at the Boston City Hospital Prenatal Clinic is that most pregnant heavy drinkers are strongly motivated by their concern for the unborn child and respond well without medication to supportive psychotherapy. The fetus is at least risk when no drugs are prescribed. Librium (chlordiazepoxide) may possibly present hazards to the fetus, however "given the choice between Librium and alcoholism I'll choose Librium", in the lowest effective dose. Of 12 pregnant heavy drinkers treated to date, only one required Librium.

Pregnancy is a period in a woman's life when she usually maintains contact with the health delivery system. It is an ideal time for identification and treatment of alcohol and drug problems. Both mother and offspring should benefit.

Henry L. Rosett, M.D.
Associate Professor of Psychiatry
Career Teacher in Addictions
Boston University Medical Center
Boston MA 02118

Our error

The November issue of **The Journal** contained a typographical error in a story on a report on long-term ganja smoking in Jamaica (page 16).

Each marijuana cigarette used in the study contained 0.9 grams of marijuana rather than .09 grams as printed.

We regret this error as did the readers who brought it to our attention.

Manitoba high school students

Alcohol use reaches epidemic level

By Manfred Jager

WINNIPEG — If alcohol abuse is considered an epidemic in modern Canada, then it should also be considered epidemic in its proportion in Winnipeg high schools, says a provincial government investigator for Manitoba.

Linda Phillips, research assistant in the department of corrective and rehabilitative services, said in an interview this month she surveyed 944 Grade 9 students in 11 Winnipeg high schools late last summer and found that 75% of them had had experience with various drugs. The drugs included alcohol, nicotine, marijuana and glue.

One of the most surprising outcomes of the survey, said Mrs. Phillips, "was that about 85% of the people who were involved in this did not consider alcohol a drug.

"Kids would actually argue with us on this, saying, 'Come on now, I know better than that. Liquor is not a drug, neither are cigarettes'," said Mrs. Phillips.

"The other things which surprised us was the relatively large number of people who had used solvents — 6.1%. We had thought there was more fear about the dangers of glue sniffing."

Forty-four per cent of the boys completing the anonymous questionnaires said they had used or were using alcohol, cigarettes, marijuana or solvents. Among girls, the level was 56%, but Mrs. Phillips said this could be because more girls than boys returned questionnaires.

Answers indicated that 67.2% of those with experience in drugs used alcohol, while 53% used tobacco. Almost 76% of the children had either experienced or were experimenting with marijuana, the survey revealed.

Mrs. Phillips said exposure to marijuana in many cases was on a one-time basis.

Most of the young people said they tried or used drugs "for kicks". The second-most frequent reason given was influence of peers or parents, that is children felt all right about liquor or cigarettes because their parents used them.

Those who said they don't use any drugs often reported fear of harm to health and fear of addiction as the main reasons for non-use, followed by peer and parent pressure against use and examples of parents not using the drug for fear of ill health consequences.

There is good evidence use of amphetamines and narcotics such as cocaine and morphine is practically absent in Winnipeg schools, said Mrs. Phillips. She said one boy reported he had had a one-time experience with heroin.

Students of parochial schools proved to be "far more innocent and much less experienced" than the other students surveyed, said Mrs. Phillips. "It could have something to do with peer pressure, the teaching in those schools, or with discipline," she said.

Liquor appears to be a more serious problem in Winnipeg high schools than nicotine, said the researcher.

"Knowing the over-all situation from the figures the Alcoholism Foundation of Manitoba has put out, and relating them to this, I'd say alcohol misuse is epidemic in school kids."

It is hard to say how many future alcoholics are going to high school in Winnipeg now, Mrs. Phillips said in reply to a question, "but there's bound to be quite a number.

"LSD, speed and other hard drugs seem to be a thing of the past. Their use has declined tremendously from about 10 years ago," Mrs. Phillips said.

She said alcohol education should be focused increasingly on the young to prevent increasing abuse and addiction in the future.

"Also, we should perhaps do more to find out why kids use drugs such as alcohol for kicks — what it is they need the kicks for in their lives.

"We should also try to find some straight answers on drugs and point out that alcohol definitely is a drug you can get addicted to and sick from, such as in cirrhosis of the liver."

Motivational research could uncover reasons why young people "feel lousy and are more apt to turn to such things as kicks from alcohol," Mrs. Phillips said.

The survey — Mrs. Phillips referred to it as a "sign-post study" — is to be forwarded to the Alcoholism Foundation for the agency's consideration in future educational programs.

Florida documents serious problem as ranks of young alcoholics swell

By Thomas Hill

ORLANDO, Fla. — A survey of high school age youths, conducted here by the Mid-Florida Center for alcoholism, found that 23% are drinking at least once a week, 55% had been drunk on at least one occasion, and 23% had had a loss of memory due to drinking.

According to Betty Jo McLeod, executive director, the centre is treating an increasing number of young alcoholics.

"Our purpose in releasing this information is to identify the existence of a serious problem and to encourage preventative education of teen-agers as well as adults," Miss McLeod pointed out. "We are not suggesting that addiction is by any means epidemic."

The survey was carried out by a mature graduate student with the assistance of classmates who questioned a sample group of 194 youths in the 15-18 age bracket. Some other figures disclosed by the survery were:

- 94% had tasted liquor;
- 86% had their first "real drink" before they were 16;
- 10% had driven when too drunk to do so;
- 28% had been to school functions while drinking.

The relationship of teen-age drinking to the attitude of parents was reflected in the following:

- 60% had their first drink with their parents;
- 64% said their parents drank;
- 7% said one or both parents had a drinking problem;
- 22% said they were not drinking because of parents' wishes.

Two findings pertained to peer pressure. They were:

- 64% said they drank just to be a part of the crowd.
- 56%, on the other hand, said they had been out with a drinking crowd but "did not always drink with them".

Putting these findings in context, the director said drinking is so widely accepted today that many parents are relieved when their children are using alcoholic beverages rather than other drugs.

"They fail to realize," she added, "that excessive drinking can lead to addiction, with consequences at least as damaging as those from heroin addiction. And there is evidence that the teen-ager can progress to alcoholic addiction much faster than persons who begin their drinking when older."

New Books

by RON HALL

Operational Definitions In Socio-Behavioral Drug Use Research 1975

... edited by Jack Elinson and David Nurco

National Institute on Drug Abuse (11400 Rockville Pike, Rockville, Maryland 20852), 1975. 66p. $6.75

Concern about the lack of comparability in definitions used in drug abuse research is given as the reason for the production of this volume which is a collaborative effort of behavioral scientists to provide a guide to definitions and concepts that have found wide use in research.

Addictions Can Be Cured: The Treatment Of Drug Addiction By Neuro-Electric Stimulation

... by Margaret A. Patterson

Lion Publishing, (121 High Street Berhamsted Herts HP4 2DJ ENGLAND), 1975 95p.1 2.95

In this interim report on her work, the author outlines the background to treatment and the development of her own electro-acupuncture method. A summary of the findings is presented and some spiritual aspects in rehabilitation are discussed.

Vagrant Alcoholics

... by Tim Cook

General Publishing Group, (30 Lesmill Road, Don Mills, Ontario M3B 2T6), 1975. 199p. $13.45

The problems of the homeless alcoholic and the way in which the Alcoholics Recovery Project in South London responded are detailed. The Project is traced from its experimental stage in 1966 to the employment of a team of recovered alcoholics in 1974 and in this development, the author discusses social responsibility and the failure of governments to take positive action. An assessment and evaluation of the Project is presented.

What Is Alcohol And Why Do People Drink?

... by Gail Gleason Milgram

Center of Alcohol Studies, Rutgers University, New Brunswick, New Jersey 08903) 1975 25 p. $0.75

In this illustrated pamphlet designed to present alcohol information in a form suitable for parents, teachers, and students, the author deals with key issues in a concise manner. The topics range from the reasons for drinking to the effects of alcohol in the body.

Other Books

The Politics of Drugs: Lang, Ronald, W. Lexington Books, Lexington, 1974. "A comparative pressure-group study of the Canadian Pharmaceutical Manufacturers Association and the Association of the British Pharmaceutical Industry, 1930-1970." 330 p. $18.50.

Drugs and Minority Oppression: Helmer, John. Seabury Press, New York, 1975. Chinese opium: blacks and cocaine; Mexicans and marijuana; Vietnam. 192 p: $11.50

The Coca Leaf and Cocaine Papers: Andrews, George and Solomon, David. Harcourt Brace Jovanovich, New York, 1975, Uses and abuses, history, religion, effects. 372 p. $16.50.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings, please send announcements as early as possible to: The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

Second Caribbean Conference on Strategies of Drug Abuse in Developing Countries — February 1976, San Juan, Puerto Rico. Information: ICAA. Case Postale 140, 1001 Lausanne, Switzerland.

The First National Conference on Drug and Alcohol Abuse Among the Elderly — Feb. 6, 1976, Valley Forge, Pennsylvania. Information: Linda Burkholder (215) 667-7972.

Conference on Interactions of Drugs of Abuse — March 9-12, 1976, New York, New York. Information: Ms E. Marks, New York Academy of Science.

American Society for Clinical Pharmacology and Therapeutics — March 18-19, 1976, Seattle, Washington. Information: Mrs. Elaine Galasso ASCPT.

Texas State Conference on Issues in Alcoholism — March 21-23, 1976, Arlington, Texas. Information: Alcoholism Council of Texas, 510 South Congress, Suite 406, Austin, Texas, 78704.

Third National Drug Abuse Conference — March 25-29, 1976, New York, New York. Information: Joyce H. Lowinson, MD, Chairperson, National Drug Abuse Conference, 1500 Waters Place, Bronx, New York, 10461.

International Conference on Alcoholism and Drug Dependence — April 4-9, 1976, Liverpool, England. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Seventh Annual Medical Scientific Conference of the National Council on Alcoholism-American Medical Society on Alcoholism — April 9-10, 1976, Washington, DC Information: National Council on Alcoholism, Inc., 2 Park Ave., New York, New York, 10016. Attention: Medical-Scientific Conference.

The Committee on Problems of Drug Dependence — June 7-9, 1976, Richmond, Virginia. Information: Committee on Problems of Drug Dependence, NAS-NRC, 2101 Constitution Ave., N.W., Washington, DC 20418.

Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies — June 20-25, 1976, Toronto, Ontario. Information: W. J. Gilliland, Conference Manager, Addiction Research Foundation, 33 Russell St., Toronto, Ontario. M5S 2S1.

Sixth International Institute on the Prevention and Treatment of Drug Dependence — June 28 - July 2, 1976, Hamburg, Germany. Information: ICAA, Case Postale, 140, 1001 Lausanne, Switzerland.

Eleventh International Conference on Medical and Biological Engineering — Aug. 2-6, 1976, Ottawa, Ontario. Information: Conference Office, National Research Council, Ottawa, Ontario, K1A 0R6.

The American University announces...

THE THIRD INSTITUTE ON DRUGS, CRIME AND JUSTICE IN ENGLAND

July 6 - 28, 1976 Christ's College, Cambridge University

This special seminar, offered for the third year by the American University of Washington, D.C., is designed for professionals and students from America and other countries in the fields of criminal justice, law, medicine, drug abuse treatment, and social work. The seminar covers heroin addiction in Britain and America, drug abuse treatment programs, and the handling of drug offenders by the police, the courts, and the medical profession; the nature and extent of crime in Britain, especially in regard to drug abuse; and the organization and operation of the police, the courts, corrections, probation and parole. The faculty from England will include distinguished lawyers, physicians, judges, criminologists, heads of drug dependence clinics, and other experts on British methods. Field visits will be made to London drug dependence clinics, criminal justice agencies, and other organizations that deal with drugs and criminal justice matters. The institute will be based at historic Cambridge University, approximately fifty miles north of London.

The institute may be taken for credit toward a bachelor or master's degree or on an audit basis. Transfer credit could be accepted by other universities and law schools at the student's request. Participants should make their own transportation arrangements to Cambridge. The cost of this travel is not included in the Institute fee.

There will be time for the participants to make individual arrangements for meeting with British professional colleagues and for tours to English cultural sites. The weather during this period in England is often ideal, sunny, and with temperatures in the seventies or low eighties Fahrenheit.

Total cost: $745, including private room at Christ's College, Cambridge, three meals per day in the college dining room, tuition for six graduate credits or two undergraduate courses, and seminar social events.

For further information, contact Dr. Arnold S. Trebach, Director, Institute on Drugs, Crime and Justice in England, Center for the Administration of Justice, The American University, Washington, D.C. 20016; or call Ms. Cathy Sacks, 202-686-2532.

Saskatchewan goes to tough guy role...

By
Karin Sobota

REGINA, Sask. — There's a popular cliche that describes perfectly this province's alcohol education program known as Aware.

The "iron fist in the velvet glove" method Aware is now using is attempting to change the public's collective lifestyle towards alcohol and its abuse.

It's a tough job for a relatively new operation. (**The Journal**, May, 1975). And it has already had its share of growing pains, aggravated by public reaction to some of its earlier efforts in alcohol education campaigns.

THE BACK PAGE

One year ago, some provincial politicians thought Aware campaigns, though slick, were soft on information and were actually *pushing* liquor into the public's lap, according to Jean Johnson, Aware's Creative Director.

As a result of this criticism, Aware changed its tactics and assumed a hard-line approach towards alcohol abuse. Aware's tag-line campaign slogan was changed from "a program for the responsible *use* of alcohol to "a program for responsible *attitudes* to alcohol".

Aware wanted the final effect of preventing non-drinkers from becoming social drinkers through peer pressure, social drinkers from becoming problem drinkers, and so on, into outright alcoholism. In other words, the project seeks to change lifestyles in order to prevent a disintegrating public.

To understand the ongoing philosophy of the campaign, one has to consider Saskatchewan's drinking habits which, according to Dr Paul Whitehead, are unique.

The province, which ranks sixth in Canada for per capita consumption of alcohol (based on the provincial population over the age of 15), has the lowest per capita increase for wine and beer, according to Dr Whitehead, a consultant to both Aware and the Alcoholism Commission of Saskatchewan. He is also a scientist with the Lake Erie Region of the Addiction Research Foundation of Ontario.

Beer consumption, according to Dr Whitehead's five-year study, has climbed less than 1% per year in the past few years and the popularity of wine also lags far behind national averages.

"Saskatchewan," he said, "with a relatively low level of consumption to the rest of the country is in an enviable position."

And Aware wants to make sure public education further enhances Saskatchewan's status.

Early in 1974, Aware's campaign began with basic information.

As Mrs. Johnson explained: "We started by looking at the situation as it was. People didn't think alcohol was harmful and our first aim was to tell them it was a drug."

Still, a credibility gap existed. Saskatchewaners didn't think of the social drinker as a driving hazard and thought only of the hard-nosed alcoholic as a potential enemy.

Today, Aware's television commercials depict middle-class cocktail parties which show the end results of those misconceptions, with a staggering "victim" winding up around a telephone poll.

All strata

Aware attempts to focus on all strata of drinking behavior in the province — from the youth stumbling out of a washroom at a pub; to the beer-bellied pseudo-athlete in front of a TV set; to the guy having a few drinks after work and the housewife sneaking a morning drink in full view of husband and child.

The newest target group in Aware's program, however, is industry.

Factory accidents caused by workers who've been drinking have, in the past, "been swept under the rug," Mrs. Johnson said.

Hard-hitting advertisements, endorsed by union and industry leaders, are now appearing in factories around the province as a reminder. The night shift is the primary focus.

Reads one poster: "The people in emergency are waiting for the night shift. Who will it be tonight? Some nice guy likely . . . who just dropped in for a beer or two before punching in for the night shift. And now he's about to injure himself on the job . . . "

Picture another scene of a stumbling factory worker trying to punch in after a few drinks.

"Sure, you cover for Bob when he goes on shift tonight. He's your brother isn't he? He's had a few beers. And he's in no shape to work a machine that involves the safety of others. Persuade him to book off sick. Or if that fails, report him . . ."

Nor is the executive forgotten.

"The liquid lunch . . . The trouble with a lot of business lunches, they make it hard to act all that businesslike when you're finished."

Young people

Aware is now being asked to establish groups in companies for employees who want to do something about their drinking problems. Indeed, said Mrs. Johnson, the Alcoholism Commission has more requests than it can handle for industrial alcohol recovery programs.

Attempts to reach young people centre on commercials aired over rock radio stations and featuring famous disc jockey "Wolfman Jack".

Finally, Aware has the ultimate ad for those who don't want to drink — The Declaration of Independence — or, how to say no to those who insist that drink be consumed.

Early in the 1974-75 campaign, the Federal Government paid a 50% share ($140,000) towards the advertising costs of the Aware program. In 1975-76, its 50-50 share with the Provincial Government amounts to $250,000 each.

Within the next few months, the results of Aware's intensive campaign will be unveiled in a study. Only then will the Saskatchewan Department of Health know the results of its "get-tough" approach to alcohol.

...Ontario stays moderate

TORONTO — Behind glossy advertising campaigns, the Ontario Ministry of Health's attempts to curtail excessive drinking habits in the Province could be summed up in the phrase, "everything in moderation".

Or, as the majority of pamphlets published by the Ministry suggest to the public: "We're not against drinking. If people want to drink, it's up to them. But we think they should be aware of: (how much it's costing them; the dangers involved; the health hazards)."

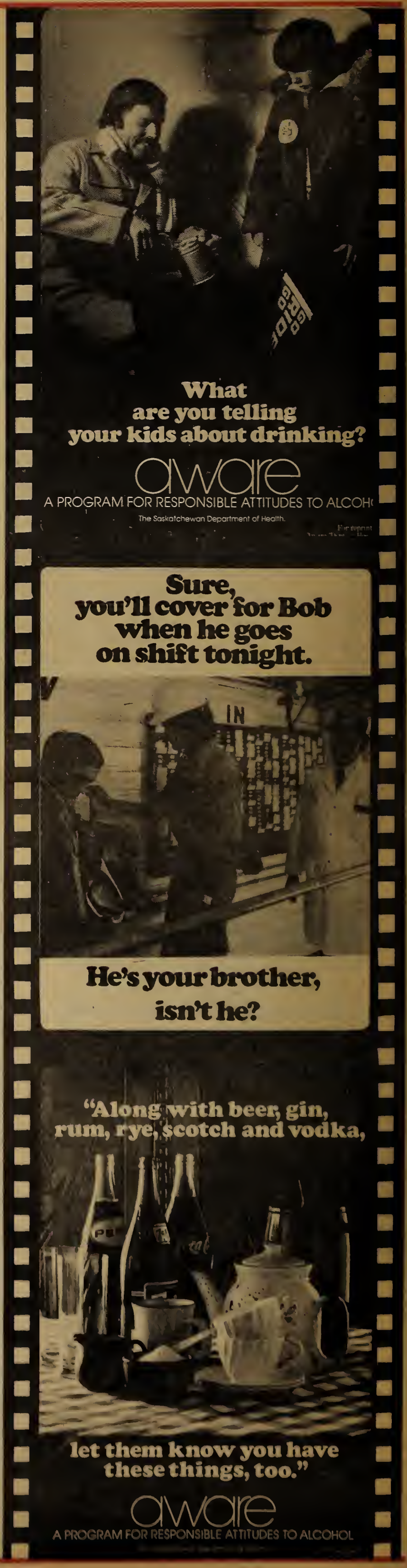
The Ministry began a comprehensive program of alcohol education two years ago. Other factors which enter into the drinking picture will be added later, according to Marion Dempsey, project co-ordinator of the Ministry's Alcohol Education Program.

These include drinking and driving, youth and alcohol, and alternatives to alcohol.

"The program," states one explanatory brochure, "is designed to inform and motivate, rather than preach." Scare tactics and threats are not part of the campaign.

Contents of the Ministry's program now promoted throughout the Province include:

- Eight pamphlets with the theme *Here's To Your Health*, distributed to the public via health information centres, mailings and other means;
- Three films available for classroom and group use;
- A series of 11 radio and five television commercials with the theme, *You are your own liquor control board*;
- Seven posters and one pamphlet designed for distribution to business and industry, using the theme, *Mix a little thinking with your drinking*; and
- Seven posters and two pamphlets with the message, *It's worth a lot more to drink a bit less*, directed at youth.



The Journal

VOL. 5 No. 3 PUBLISHED MONTHLY BY ADDICTION RESEARCH FOUNDATION TORONTO March 1, 1976

This is what happens if you smoke when you're pregnant.

Every time you inhale you fill your lungs with nicotine and carbon monoxide.

Your blood carries these impurities through the unbilical cord and into your baby's bloodstream.

Smoking can restrict your baby's normal growth inside the womb.

It can make him underdeveloped and underweight at birth.

Which, in turn, can make him vulnerable to illness in the first delicate weeks of his life.

It can even kill him.

In just one year, in Britain alone, over 1,500 babies might not have died if their mothers had given up smoking when they were pregnant.

If you give up smoking when you're pregnant your baby will be as healthy as if you'd never smoked.

Is it fair to force your baby to smoke cigarettes?

Britain's Health Education Council is continuing its campaign against tobacco with multi-media publicity that shows smoking not only as a health hazard but also anti-social, ugly and expensive. *Complete story on page 2.*

Pot decriminalization

It's inevitable say experts

By Anne MacLennan

NEW YORK CITY — Cannabis will be decriminalized through the United States and sold — perhaps through government outlets — within the next four or five years.

The predictions came at the end of what some people called "the last of the big cannabis meetings". And when they came, they seemed both the inevitable result of the three-day scientific meeting and yet something quite apart from it.

Inevitable because scientist after scientist, many of them researchers on one of the three major series of studies of chronic cannabis users — in Jamaica, in Greece and in Costa Rica — acquitted cannabis of causing dramatically deleterious effects.

Apart from it because already, and conceivably neither despite science nor because of it, the move towards decriminalization has gathered enough momentum to take it at least across the United States.

Michael Sonnenreich, a Washington lawyer who has been involved in critical review of much of the US cannabis legislation and who was director of the National Commission on Marijuana and Drug Abuse, was one of the speakers at the final session of the meeting — Social Policy and Marijuana Use.

"Whether marijuana is more harmful than we at present surmise, or less harmful, is a question of degree not a question of new revelation.

"My own feeling about the social change with respect to marijuana is that change is inevitable. It's a question of time.

"When California went, (decriminalized) 10% of the population of the United States went with it . . . The reality is you're going to see another state go and another state . . . The federal law will change when we've got about 30 or 35 states.

"People have to be aware of the fact we are in transition and I don't think there's any question about it. The transition is occurring. The degree of transition and the speed of transition can be held up by a variety of factors. But, I don't think it's going to stop.

"I think the momentum is there and it's going to carry — whether cannabis use carries civil fines and everybody for-

(See — 29 million — page 5)

Dr DuPont plays down cannabis threat

WASHINGTON — In his first public comparison of marijuana with alcohol and tobacco, the head of the National Institute on Drug Abuse maintains the two popular "recreational" drugs cause far greater health problems than does marijuana.

Marijuana, said Dr Robert DuPont, lacks the lethal effects of either alcohol or tobacco.

At a press conference where he issued the fifth annual marijuana and health report, Dr DuPont held that civil penalties should be substituted for criminal prosecution for possession of marijuana.

"Personally, my view is that we do not have to threaten young people with imprisonment to discourage the use of marijuana," he declared. (In recent months, several states

(See — Ford — Page 3)

A 'galloping consumption'

Canadians wolfing down pills

By Milan Korcok

HAMILTON — A McMaster University study has revealed a "galloping consumption" of medical drug use among Canadians, and has warned that physician-induced drug abuse may be emerging as "a socially significant phenomenon".

The study, prepared by the university's department of clinical epidemiology and biostatistics, under the direction of Dr Abraham Chaiton and Dr Walter O. Spitzer, notes that 60% of the people studied had taken at least one medicine in the 48 hours prior to interview, and 30% had taken at least one drug prescribed or suggested by a doctor.

The McMaster study, published in the *Canadian Medical Association Journal*, (January 10), was based on interview surveys of 20% of the households in Smithville, a rural south-central Ontario municipality; and a random sample of families receiving their primary medical care from a suburban family practice in Burlington, Ontario.

To minimize the chance of error in subject recall, questions concerning drug use were limited to use within the previous 48 hours.

The questions related to pain relievers, cough and cold remedies, laxatives and stomach remedies, vitamins and tonics, sleeping pills, tranquillizers and sedatives, oral contraceptives, antibiotics, and medicine for the heart and blood pressure.

Data revealed approximately 58% of the people interviewed had taken at least one non-prescription drug in the previous 48 hours, 25% had taken two, and 20% three or more.

In terms of prescribed medicines, 36% of the respondents in the Smithville community survey had taken at least one drug in the past 48 hours, as had 29% of those in the family practice survey.

The most frequently-used prescribed drugs were tranquillizers and sedatives. Among people 20 years and more, 8.8% of those in the community survey, and 10.5% in the practice survey, reported using tranquillizers in the 48 hours prior to questioning.

Use of these drugs was twice as prevalent among females as males, and more than 50% of sedative and tranquillizer users were 50 years and older.

The report notes that oral contraceptives were used by close to 15% of the respondents in the Smithville survey, and 17% in the practice survey.

Antibiotics accounted for only 1.7% of prescribed drug use in the community survey and 2.4% in the practice survey.

(See — Canadians — Page 2)

BC chief named

VANCOUVER, BC — The Journal learned at press time that Herbert Hoskin, former director of the British Columbia Narcotics Addiction Foundation, has been appointed acting head of the Alcohol and Drug Commission here.

He replaces Peter Stein who, along with the five other commissioners, was fired in January by the new Social Credit government.

The commission will be reorganized, with three commissioners instead of six, and an Advisory Committee comprising civil service representatives from the departments of health, education, finance, human resources, and the Attorney General, and from professionals involved in drug treatment. The commission offices have been moved from Victoria to Vancouver.

... INSIDE

Canadians using more pills to treat ills

(continued from page 1)

The amount of self medication with over-the-counter drugs caused some concern among the report's authors. Between 25% and 28% of respondents had used vitamins or tonics in the 48-hour period prior to the interview, yet such use was suggested by the physician in only 40% of the cases.

For pain relievers (including ASA) self-medication was 2.6 times more frequent than was physician-prescribed use. The data also shows that at least twice as many persons treated their own colds as went to physicians for treatment.

Use of laxatives and stomach medicines was instituted just about equally by physicians and consumers.

One of the factors built into this study was an evaluation of the effect of nurse practitioners on patterns of drug use.

As part of the Burlington study, families were randomly assigned to a physician or nurse practitioner at the start of the trial.

Among those assigned to a physicians over a one-year period there was no change in frequency of use of tranquillizers and sedatives.

Among those assigned to a nurse practitioner, there was a "significant decrease" in use of the drugs. The nurse was allowed to recommend medicines, but all prescriptions were confirmed or countersigned by the physican.

The authors believe the most likely explanation for the reduced use of tranquillizers and sedatives among patients of nurse practitioners was the probability that nursing training had emphasized management of psychosocial problems with minimal use of medications.

"Confirmations of our findings in other settings is important," the authors emphasize.

"This analysis exposes Canadian society's considerable dependence on drugs in everyday life.

"Pharmacological support for prophylactic, symptomatic, or curative purposes is apparently accepted by 60% of Canadians at any one time.

"The extent of medical use of drugs is of sufficient magnitude to warrant monitoring on a periodic or continuous basis."

The authors add: "The pattern and appropriateness of physicians' prescribing practices justify concern that iatrongenic (doctor-induced) drug abuse may be emerging as a socially significant phenomenon."

New assay measures pot level in body fluid

LOS ANGELES — A new radioimmune assay technique developed by a California group provides a relatively simple, rapid and inexpensive method to measure marijuana in body fluid.

The new assay, using a special goat antiserum, has demonstrated a high degree of accuracy and specificity for detection and quantitation of delta 9-tetrahydrocannabinol (THC) and its metabolites in blood and urine, according to Dr Stanley Gross, professor of anatomy at University of California School of Medicine here.

Illustrating the sensitivity of the procedure, Dr Gross said Delta 9-THC can be quantitated in body fluid 15 minutes after a person has smoked a single marijuana cigarette.

The studies by Dr Gross and his co-workers are supported in part by a grant from the National Institute on Drug Abuse.

Two scientists maintain

Control group research is limited

LONDON, Ont. — Two Canadian scientists claim control group research, the major research technique in psychotherapy, should be replaced by studies of individuals.

Professor Bradley Bucher says control group research has been costly and limited. Both he and Dr Robert Brook claim descriptions in publications are so short on detail that experiments cannot be repeated.

Prof Bucher, of the University of Western Ontario's department of psychology, takes a behaviourist's approach to psychotherapy.

Although Dr Brook's approach to counselling differs from Prof Bucher's, the two men reach similar conclusions about control group research.

Dr Brook, director of the Lake Erie Region of the Addiction Research Foundation, says his aim in psycho-social counselling is to help the client recognize his personal responsibilities, start behaving in ways to fulfil these, and discover "what it is he believes or trusts".

In a recent paper, Prof Bucher says it is difficult in a classic experimental design to control all variables associated with the technique, the client, and the therapist, that are not central to what the researcher is measuring.

A better research method, according to Prof Bucher, is a "within-subject design" in which the experimenter manipulates each subject's dependencies by giving rewards when the subject produces behaviours the researcher wants.

Because clients respond only to reinforcers related to their own environments and behaviours, past experiences seem certain to be important factors in treatment outcome, Prof Bucher writes.

Treatment procedure is flexible because the clinician continuously observes his patient's responses to stimuli, he says.

In another paper, Dr Brook says: "The utilization of sufficient control in human endeavours (to fulfil the criteria scientists say are necessary to do an experiment), given our current political and social fabric, would violate community norms."

He says researchers and clinicians often attribute to each other uncomplimentary personality traits and are still arguing whether psychotherapy is an art or a science.

If it is viewed as an art, a dynamic relationship that is seldom repeated exactly, it cannot be studied in experimental control groups, Dr Brook says.

The way for therapists to combine the artistic and scientific part of counselling is to observe, note, and monitor the responses of single subjects, he says.

Dr Brook learned as leader of the 414 project, a residential therapeutic community to assist poly-drug using adolescents, that role conflict can lead people giving treatment "to compromise design in favour of clinical responsibilities".

For example, clinicians in the project sometimes felt reluctant to "sacrifice" subjects to the control group because they felt the experimental therapeutic community offered better treatment. Patients often did not want to be told where they would have to go for treatment.

'Filthy, ugly, smelly' habit under UK fire

By Thomas Land

LONDON — Britain's national Health Education council has launched a unique new multimedia publicity campaign designed to counter traditional teenage beliefs about smoking.

Television, cinema, press and radio advertisements are telling teenagers throughout the country that smoking is not only dangerous to their health — but also anti-social, ugly and expensive.

In a typical television advertisement, a boy tells his girlfriend: "Your breath stinks of tobacco".

And in a cinema advertisement, a girl refuses to kiss her boyfriend because (as she tells her friend): "He's very nice, but his breath smells like you'd get lung cancer just kissing him".

A holiday romance ends in a radio commercial with an exclamation by the girl: "Phew, what a letdown. His breath reeked of stale tobacco and his mouth tasted like an old fag end".

Boys are advised in a newspaper advertisement that many potential girlfriends are likely to turned off by the "filthy habit" of smoking.

This campaign is the first of its kind in Britain to be directed specifically at a teenage audience. It is to run three months, at an estimated budget of $200,000. Its underlining message is that personal relationships as well as health can be harmed by smoking.

The advertisements are an attempt to counter the established images of smoking as a sophisticated and mature habit, explains Alastair Mackie, Director General of the Health Education council.

Much cigarette advertising is aimed at convincing young people "that smoking is a grownup habit which puts a man or woman-of-the-world gloss on the smoker," he says. "We are putting the true facts across — that smoking is a dirty habit which can cause offence to others and even make smokers less attractive sexually than non-smokers.

"This campaign is a coordinated attempt to rid youngsters of what more and more people are recognizing as one of their most evil predators."

Although smoking appears to decline among young people in most social classes, the Health Education Council says that "those in the unskilled and unemployed groups as well as those who do worst in school seem the least able to resist the lure of cigarette advertisements.

"We are also concerned that children are taking up smoking at an increasingly early age."

Politicians prefer 'phuzz phrases'

By Wayne Howell

EVER SINCE the Ontario drinking age was lowered to 18 from 21 in mid-1971, the number of 16- to 20-year-olds involved in alcohol-related traffic accidents has risen in dramatic fashion.

Could there be a relationship between these two events?

The North York Town Council thought so, and passed a motion urging Ontario's Premier Davis to raise the drinking age and hopefully stop the carnage.

The Premier's response? In a letter to the council he blamed the whole mess on 'the general affluence of society combined with a general weakening of parental and other authority'.

Zingo — from the particular to the general; from the immediate problem to a Spenglerian overview; from the decline of adolescent abstinence in Ontario to the decline and fall of Western Civilization!

How was it done? By the judicious use of the phuzz-phrase, the hottest thing to hit the rhetoric market since the advent of the buzz-word some years back.

What exactly is a phuzz-phrase you ask? Perhaps the easiest way to answer that is to print an extract from a standard phuzz-phrasebook:

	A	B
1.	Progressive	Breakdown
2.	Systematic	Decline
3.	General	Deterioration
4.	Insidious	Weakening
5	Continuous	Crumbling

C

Social Value System
Community Restraints
Parental Authority
Social Support Systems
Societal Mores

Readers of **The Journal** will immediately recognize this as the familiar 'Centre-Cannot-Hold' phuzz-phrase list that is so beloved by academics and public spokesmen in the addictions field. They need look no further than the December 1975 issue of **The Journal** to find a report of a keynote speaker at a Community Action on Alcohol Conference attributing alcoholism to A1-B1-C4, that is to say to 'a progressive breakdown of social support systems'. The Premier's response to the North York Council was, of course, a simple variant from the same phuzz-phrasebook, an A3-B4-C3.

But what, you ask, if you have persevered to this point, is a phuzz-phrase good for?

Phuzz-phrases are handy-dandy intellectualizations that appear to illuminate but in fact only serve to obfuscate. (Is it any wonder that politicians find them irresistable?).

They do this by turning one's attention away from the specific concern such as beer-besotted teen-age drivers, to The Big Picture — declining productivity, violent crime, inflation, teen-age drinking, marriage breakdown. Can't you see, asks the phuzz-phraser, that the real problem is not the mundane parochial concern of the moment (such as teen-agers cruising about the streets with more than 0.08% alcohol in their blood)? The basic problem, the real gut issue that has to be faced is A1-B2-C3, it is A2-B2-C5, it is A4-B4-C2. Yes by God it is A5-B5-C5!

That's the problem, says the phuzz-phraser, and how naive it is to think you can do anything about it by making little legislative adjustments here and there such as raising the drinking age back up to 21 and waiting to see what happens.

No Sir — what we need, as any phuzz-phrasing social scientist or politician will tell us, is a 'renewed awareness of personal responsibility', a 'systematic restructuring of community values', or a 'return to traditional social mores'.

In short, what we need is A2-B3-C4, A3-B2-C1, and A1-B4-C2 from the familiar 'Radical Transformation' phuzz-phrasebook so beloved by procrastinating politicians and intellectualizing academics.

Love those phuzz-phrases — I mean what is the Premier of the province supposed to do, write back to the North York Council and say 'we goofed'?

Ford 'clearly wants to open discussion on marijuana'

(continued from page 1)

in the US have moved to "decriminalize marijuana possession.)

While Dr DuPont has made similar remarks at professional meetings over the past year, the press conference marked the first time he declared his current views in a public forum.

While his comments do not represent a major shift in Administration thinking, observers were quick to point out that the Ford Administration clearly wishes to open up discussions around marijuana.

"If there is a difference between the Nixon and Ford Administrations," NIDA Deputy Director Karst J. Besteman told **The Journal**, "it's in the fact the Ford Administration is much more willing to have staff professionals and scientists discuss these (marijuana) issues in an open and intellectually clear fashion.

"Previous policy did constrain these discussions."

Dr Besteman said his boss did not draw the comparisons of marijuana with alcohol and tobacco to indicate that "cannabis is innocuous".

He said, alcohol and tobacco were simply used as examples of a "real horror chamber to reflect the devastation these drugs have had all over the land".

"If we had as many pot users as (tobacco) smokers, Dr Besteman added, "we'd be in a hell of a mess."

The latest marijuana and health report shows marijuana smoking in the United States has significantly increased over the last two years, especially among the younger age groups — those aged 18 to 25.

In this age group, more than half have smoked marijuana at least once.

Recent studies, says the report, also indicate. that "whereas some five years ago smoking pot was the symbol of counter-culture movements, today it has lost some of this anti-establishment symbolism"

The report also deals with the long-term effects of marijuana on health and behavior, and reviews some recent research findings indicating the drug may be useful in managing disorders such as asthma; the eye disease, glaucoma; and for the relief of secondary problems associated with the drug treatment of cancer.

Dr DuPont says the "recreational" drugs tobacco and alcohol cause greater health problems than marijuana. Head of the US National Institute on Drug Abuse, he adds that marijuana lacks the lethal effects of the other two drugs.

The new report reveals figures from a recent national survey which show that 53% of people aged 18 to 25 years have tried marijuana at least once. A survey in 1972 indicated 48% of this age group had tried marijuana. The latest survey was made in the latter part of 1974 and the early months of 1975. One in four of those sampled in this survey indicated they had used marijuana within the last month.

The report cites a gallup poll in 1967 among college students which found that only one in 20 had used the drug. By 1974, more than half — 55% — said they had used marijuana.

"In seven years, what was once clearly statistically deviant behavior has become the norm for this age group," the report states.

"While in previous years, use of marijuana was corelated with education, (the better-educated tended to use the drug), the percentage now reporting marijuana use is virtually identical for high-school drop-outs, high-school graduates, and college graduates in similar age ranges."

The report notes the relatively recent addition to the illicit drug market of hashish oil, a substance having a Tetrahydrocannabinol (THC) concentration of 40% to 50% as compared with the 1%-2% THC content of marijuana ordinarily available in the US.

Increasing availability of such potent preparations may have quite new implications the report observed: Stronger preparations may be more difficult to control and may result in marked impairment in driving and other similar skills.

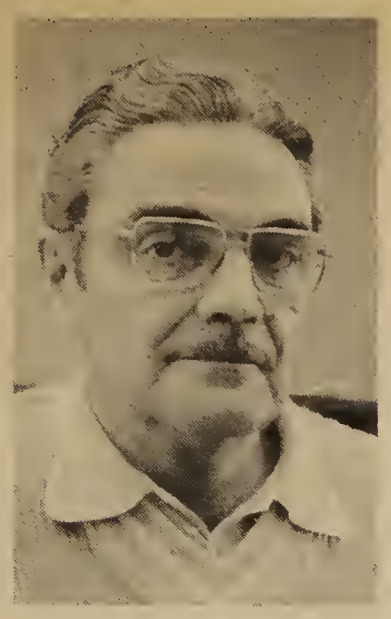
One distributing trend noted in the report is in the increasing tendency for marijuana use to go hand-in-hand with that of alcohol. Previously, marijuana use often involved actual opposition to the more traditional use of alcohol.

"Now those who use marijuana are also very likely to use alcohol — frequently simultaneously," the report states.

The report weighs this development in considering what it describes as "significant hazards" of marijuana smoking — the impairment of psychomotor performance among automobile drivers, pilots, and people who work with machinery. The simultaneous use of alcohol and marijuana by drivers "poses a threat that may well exceed that of either substance alone".

In this connection, the report notes there may soon be a simple "roadside test" available for detecting those under he influence of marijuana, paralleling that of the breath test for alcohol.

While marijuana use has risen among the younger age groups, it has not become correspondingly popular among people in the older age groups. Among those aged 26 to 34 years, less than one-third have ever used marijuana. In oder age groups, use is even less



Wilfred Totten

Wilfred J.Totten

Anticipating problems should be goal says new Alta chief

"If you're right only 50% of the time, it's better than no plan at all."

EDMONTON — Society should "pre-act, not react" to the potential harm of intoxicant use, declares the new head of Alberta's Alcoholism and Drug Abuse Commission.

But, quickly adds Wilfred J. Totten, that does not mean more public education programs.

"I hope 'education' is a word that soon comes out of our vocabulary. I think it stereotypes our thinking.

"It's probably helpful — and I think it has to be part of our comprehensive preventive approach — but there are limits to what you can do with education alone.

"Everybody is educating everybody else now about something. The amount of stimulus! It's just normal that people can't react to all those things, so I think we have to try something else."

That is the basic appraisal of an AADAC commission chairman and executive director, appointed late in 1975. He sees his new role as more that of a delegating manager and consolidator of previous gains than an instigator of remarkable new policies.

Beyond that, Mr Totten's philosophy appears to have its roots in a personal skepticism that any development, however innovative, will suddenly resolve problems of intoxicant use that are as old as mankind itself.

He praises groups like the Addiction Research Foundation of Ontario, which has advocated manipulation of beverage licences, and raising of liquor prices, as a way of reducing consumption. But he stops short of advocating a return to the 21-year minimum age limit for legal drinking.

He concedes ARF studies show raising the age limit might help reduce rates of teen-age alcoholism traffic accidents and convictions for impaired driving.

"So there's a tendency to jump to the conclusion that it (a lower age limit) was a bad thing, and therefore we must reverse it and send it back to 21. I'm not convinced that is a very viable type of position.

"But I think if governments were to legislate that, it might convince the public there was a commitment to do something about the phenomenon. Whether that would be doing it right, or not, is something else again.

"That might be the benefit, but beyond that, I just don't know at the moment."

In Alberta, at least, he suggests a preventive approach may be the most realistic answer to alcoholism and drug abuse.

"I don't think tokenism is going to do us much good.

"If we are not prepared to make a commitment like that, we'd just better forget it, and get on with picking up the debris after the fact."

Instead, he proposes that agencies try harder to anticipate problems and solve them before the issues become critical.

"If you're right only 50% of the time, that's better than having no plan at all. That's part of the whole process of management — looking ahead. Government agencies haven't tended to do this as much as I think they should."

"It's extremely difficult. Agencies like ours have been trying for years, with little improvement in the success-failure ratio." Mr. Totten, in fact, hopes terms like "success" and "cure" will disappear from the addictions field.

"We can't measure what we do in those terms," unlike the more traditional health disciplines.

Meanwhile, if society does not develop and support effective techniques to help people avoid the traps of chemical abuse in the first place, the most tangible result of programs like AADAC "will be to provide me and a number of other people with jobs until retirement," the chairman emphasizes.

"I'd like to have a job, but I'd also like to think we could take seriously a reasonable goal of some day dealing with the problem, so they wouldn't need us around here."

CPA recomendations

Members want a larger role in tackling drug problems

By Dorothy Trainor

MONTREAL — The 2000-member Canadian Psychiatric Association will play a much more active role in curbing the hazards and prevalence of non-medical use of drugs, including alcohol — if present recommendations are implemented.

The recommendations, now approved by the Board of Directors, indicate alcoholism is a prime concern. For instance, one recommendation is that the CPA exert "its somewhat neglected responsibility" in this area by initiating and co-sponsoring with other organizations a national conference on alcoholism.

Dr John Unwin, a McGill University associate professor of psychiatry, prepared the recommendations after consultation with such experts as Drs Lionel Solursh of Toronto and Philip Katz of Winnipeg.

In an interview with **The Journal**, Dr Unwin admitted there has been little direct CPA action in the past concerning drug and alcohol problems.

"In the general field of prevention of the non-medical use of drugs, the CPA has not given the leadership and expertise that Canadian communities have a right to expect.

"Instead, there has been a tendency to react to the policies of other medical groups rather than initiate and stimulate original programs," he said.

If put into practice, the new recommendations may change this.

A special thrust of guidelines set up will concern the teaching of medical students about the misuse of drugs and "frequent iatrogenesis", (doctor-caused disease). This reflects CPA awareness that imprudent prescribing has been a serious problem.

In-training teaching of students, it is proposed, will be followed by continuing post-graduate education.

Other policies recommended refer to instructive measures for the psychiatrists themselves and the need for Canadian psychiatrists to "take every opportunity to inform and advise their non-psychiatric colleagues".

With respect to cannabis control, the recommendation is that the CPA continue to support the Canadian Medical Association's brief to the Senate Committee on this matter.

Although this brief suggests smoking marijuana or hashish creates definite health hazards, it disagrees with the retention of criminalization which may result from simple possession.

Jail sentences and criminal records, it says, may result in "far more serious, deleterious effects than the use of the drug".

Conference on Chronic Ca

LeDain Commission member warns

To legalize pot would be a mistake

IT WOULD be a serious error for Canada to legalize marijuana, according to Dr Ian Campbell, a member of Canada's LeDain Commission.

In an interview with **The Journal**, Dr Campbell said he is still not prepared to say it is not a dangerous drug.

"Reducing the criminal penalties is one thing, but to legalizè would be a serious error," said Dr Campbell, Dean of Sir George Williams Faculty of Arts and professor of sociology, Concordia University,Montreal.

"I think we've gone so much too far in the so-called liberalizing of the alcohol laws. The reduction of the drinking age was a profoundly stupid thing. If we hadn't done it, I don't think we'd do it today, at least not knowing what we know now and unless we were more than usually crazy."

He said intoxicants in general are harmful. "Especially with reference to cannabis, the balance of the evidence I think suggests that for mature people — people in their 30s and 40s — there are a lot fewer serious consequences of cannabis use than of alcohol use.

"The one reservation I have here, and I think it's important, hinges on the ease of use. This has always terrified me about cannabis in any population.

"It's so easy in a traffic jam to light a joint. It's much easier to do than to reach in the glove compartment and get out the gin and the shaker and make the martini. On top of which, the policeman is much more likely to see the martini."

However, for young people, "I think cannabis has very real dangers, along with any intoxicant perhaps. For those between 12 and 18 years of age there are enough problems of maturation that the use of intoxicants just doesn't help. I'm not sure that even tranquillizers aren't prescribed much too much in this period.

"So, I am as worried now as I was when we reported, about young adolescents' use of cannabis. I think it's a highly dangerous drug there along with any other intoxicant, any other drug, at that time.

"What the politicians will do (with it), however, is another matter," he said.

One of the few Canadian speakers at the meeting, Dr Campbell discussed the amotivational syndrome and cannabis use with emphasis on the Canadian scene.

He said since 1973, about the time the last LeDain Report was submitted, interest in Canada in the amotivational syndrome had waned both among scholars and "that diminishing part of the public involved in debates concerning drugs and their effects".

"More than the other members of the commission, I was, and remain, concerned that a significant drop in motivation is a consequence that may, in some individuals, be associated with the continued use of a number of psychoactive drugs, including cannabis.

"I stress that I do not find it as a unique consequence of cannabis use for I have seen the same symptoms in a large number of chronic and heavy users of alcohol."

He said his concern stems largely from observations of 275 university students who had smoked cannabis. In addition to observing the students he held interviews with 127 of them.

"A year by year analysis of final examination averages . . . showed that the greater their use of cannabis, the greater the tendency for there to be a drop in final averages. Final averages dropped in 77% of the heaviest users and 32% of those who were lightest users. The heavy users also had a higher failure rate and lower averages than the light users."

He said this could be attributed to many sources, including their heavy cannabis use; participation in a sub-culture which did not tend to stress academic success or the acceptance of such values as planning, punctuality, concern with the future, and rationality, which tend to be associated with academic success. Or, it might be attributed to a general decline in motivation.

"My interviews with and observations of these students certainly suggested apathy increased and vitality diminished as frequency of cannabis intoxication increased.

"It seemed very clear that after periods in which they smoked cannabis four, five or more times a week for a month or six weeks, there was a lessening in the quality of abstracting and synthesizing. However, the quality returned following the summer vacation when the students were free or largely free of cannabis use for up to four months.

"It seems to me not unreasonable to hypothesize that a loss of synthesizing and abstracting capacity could yield a change in motivation and, at least in part, account for the apathy and other behavior that would be described as the amotivational syndrome."

He said a better way of describing the impairment might be to say there was a lessening of "the capacity to perceive relationships of appropriateness".

"Such impairment would surely influence the use these students made of their potential and could well affect motivation".

Alcohol may have to go

IF CANNABIS smoking becomes widely accepted, something, probably alcohol, is going to have to go, according to Dr Nancy Rubin.

"People are becoming more and more aware of the real risks inherent in alcohol. In Jamaica, psychiatrists on our project made the remark — specific remarks based on our studies — that ganja is a benevolent alternative to alcohol and there is nothing that turns up in the mental hospitals (as a result of cannabis use) which shows any of the sequellae that you get from alcohol," Dr Rubin told **The Journal**.

Dr Rubin, who was chief investigator in the Ganja in Jamaica study (**The Journal** September 1975), is director in New York of the Research Institute for the Study of Man.

"Smoking cannabis is bad for you as we determined in our Jamaica study. Even though it wasn't a very significant finding, the trend was there. Whether this can be controlled in relation to the paper or elimination of tars or whatever, within the smoke itself, is a technological problem. It may or may not be solved.

"However, lots of people are apparently still willing to take risks with cigarette smoking, myself included. And we're beginning to learn more and more about the long-term effects of chronic use."

She said despite some of the criticisms of the Jamaica study (focusing on the fact that Jamaican peasant workers have little in common with educated people in sophisticated societies) "physiological processes are the same universally".

"If cannabis effects are not lethal in one society, they are not going to be in another."

Cannabis effects are "definitely not lethal and they're not pathological. A great many of the lurid dramatic claims that were made about it have simply been disproven.

"So, people have to make a choice."

'It was cheaper than a movie'

Small turn-out called healthy sign

SCIENTISTS MAY have stopped playing to the gallery and started to focus seriously on the next scientific steps in the cannabis question, according to Dr Daniel X Freedman.

Dr Freedman, professor of psychiatry at University of Chicago, and editor of the Archives of General Psychiatry, was commenting on the relatively sparse attendance

For, despite a list of speakers which included some of the most prominent cannabis researchers and debaters in North American and abroad, the turn-out, to put it kindly, was sparse.

Organizers at the New York Academy of Sciences reserved space for about 700: Only about 225 registered.

Public Relations Director Ann Collins is still trying to figure it out. It was widely advertised — even in Canada, she said.

And it couldn't have been the price — $35 for regular observers and $2 for students. "At $2 it was cheaper than a movie," said Ms Collins.

It was food for conversation at the meeting however. Corridor jokes had it that there were more speakers and media people than observers.

Some said cannabis was a dead issue anyway. Others that it was a big mistake to get involved in a political issue in the first place and people were beginning to realize it.

Dr Freedman, however, was most positive: He thought it was "a healthy sign". "We have a conference of distinguished scientists and some interesting data on hashish and it's relatively uncrowded."

The gallery having left?

We've no immunity to danger: Freedman

THE LURKING agenda behind society's interest in cannabis studies is whether marijuana should be one's recreational drug of choice.

Daniel Freedman

But that should not be the scientist's agenda, according to Dr Daniel X Freedman, professor of psychiatry, University of Chicago, and editor of the Archives of General Psychiatry.

"The real concern in our western society is, can the scientist come up with something that will allow us to avoid making a value judgement on how we want to utilize chemicals? And that's a value judgement.

"The scientist's job is to have a variety of interests in a molecule that somehow or other makes the brain function differently. His job is to assess whether or not there are specific health hazards that it would be useful to know about.

"If the scientist takes a scientific challenge and works at it, if he tries to answer questions beyond what the methods equip him to do, he cannot do a good scientific job, cannot have watertight scientific validity.

"There are two agendas — one is the value agenda and the other is the scientific one."

On the scientific agenda, what should get priority?

"Science has a funny way of engendering its own priority in accidental fact-finding. The testosterone findings, equivocal as they are, may be of interest to endocrinologists for quite different reasons.

"It could be a goose chase of great academic interest to scientists. You never know when a finding becomes a truly scientific finding.

"There's no danger to immunity that I can see. But then there's no immunity to danger. If you want a guarantee of no surprises, the thing to do is lock up your scientists and let your kids and society go their own way. Scientists are a menace because they may come up with unexpected findings."

He questioned the "frenetic energy" being devoted to pot "at a time of vast social change and institutional shifts. I've said before use of a drug will be arrived at by consensus. That means practices.

"When those practices carry with them any kind of change between generations — any promise of change — then it is the concern of parents as to what they want their children exposed to.

"The world might little note or long remember what we do about or don't do about pot. There are so many issues.

"At the bottom of it you know is who will capture the mind of the child. Nations have gone to war over that. What do you tell the kids?"

nabis Use:

Anne MacLennan, associate editor of The Journal, reports from a meeting held by the New York Academy of Sciences and sponsored jointly by the National Institute of Drug Abuse and the New York Medical College. It was held in New York, January 26 to 28.

Chronic heavy use studies reveal few pot dangers

A SERIES of studies of long-term cannabis users in Costa Rica essentially supports and extends the findings of a similar set of studies among Jamaican users (**The Journal**, September 1975).

In the Costa Rica studies, investigators found there was no permanent or irreversible impairment in higher brain function or intelligence in users; cast "serious doubt" on the theory that chronic use lowers blood levels of testosterone (the male sex hormone); and found no evidence of impairment in the body's natural defence mechanisms.

The brain function study also unearthed no evidence to support the theory that heavy cannabis use provokes an'amotivational syndrome'.

Reporting on the study of neuropsychological, intellectual and personality correlates, Dr Paul Satz of the University of Florida said: "The final word concerning the question of brain damage in humans cannot yet be given." (The study was done in conjunction with University of Victoria, B.C.)

"But, present results do not favor hypotheses postulating brain damage as a consequence of marijuana intake. Nor is there any strong evidence in the human literature to warrant such an hyothesis" he said.

As for the personality area, the study was "essentially similar to previous largescale controlled studies which have likewise failed to demonstrate any significant personality disturbance in chronic marijuana users.... No abnormal or deviant personality traits emerged".

He said findings lent "no support at all to the rather absurd speculations concerning an amotivational syndrome or organic brain defect following chronic marijuana usage".

Dr Satz did say, however, that the results should not be taken to mean that marijuana use is an insignificant social or personal event with no influence on individual behavior.

Anthropological data revealed at least three different marijuana life styles in Costa Rica, he said.

In the study, 41 long-term users and 41 matched controls were examined. Users in the final sample smoked about nine cigarettes each day for an average of 17 days.

Dr Satz said: "It is hoped that the additional methodological controls employed in the present study, by investigators with no vested interest in the results, will buttress what is clearly becoming a majority finding — namely that chronic marijuana use does not irreversibly damage the brain or personality."

He suggested future studies should consider the use of prospective and retrospective longitudinal designs... "There is no substitute for having repeat observations on the same subjects over time, preferably *before* and *after* exposure to marijuana.

"This type of design would settle, once and for all, the delicate issue concerning precursor variables in personality and subtle brain changes, if any, following chronic marijuana usage."

In another University of Florida study of the health status of chronic heavy cannabis users, people who had used cannabis three or more times a week for at least 10 years were examined.

Dr W. J. Coggins reported users were not different from the matched control group. Although their medical histories showed more symptoms of gastro-intestinal discomfort and their body weights were lower, none was markedly underweight.

Users more often had positive serological tests for syphillis than controls but none was found to have active infection with syphillis.

There was no other evidence of an increased incidence of past or present infections in the users suggestive of impaired immunological responsiveness.

Abnormal chest x-rays were as frequent in controls as in users and testosterone levels were no different in users than in matched controls. "There was no relationship between levels of marijuana use and levels of testosterone," said Dr. Coggins.

In a third University of Florida study, researchers found marijuana use did not result in behavior which impaired the individuals' ability to function as regular members of society.

Significant differences between users and non-users tended to antedate marijuana use and continue to be reflected in later life, reported Dr William E. Carter.

"Marijuana use as found among working class men in San José functions largely as a device which they feel aids them to cope with their daily routines and problems."

Alcohol for courage – pot for tranquility

ALCOHOL WAS significantly more socially disruptive than cannabis in a group of delinquent adolescents studied at Stanford University.

This was despite the fact the two drugs were used with about the same frequency, Dr Jared R Tinklenberg reported.

He said alcohol use had been involved in more fights, more difficulties with police and other authorities, more trouble with family or friends, and more automobile accidents than cannabis.

While the youths said they used alcohol to "bolster courage", they used marijuana as a tranquillizer and to avoid difficulties.

"On a variety of measures designed to identify drug effects on assaultive behavior, the findings of this study were consistent — cannabis usually reduced assaultiveness and alcohol often enhanced assaultiveness," said Dr Tinklenberg.

The study was done by researchers at Standord University School of Medicine and Veterans Administration Hospital, Palo Alto, California.

"Among young people in the United States, an increased consumption of cannabis over the past 10 years has occurred contemporaneously with an increase in assaultive crimes and other forms of social behavior," said Dr Tinklenberg.

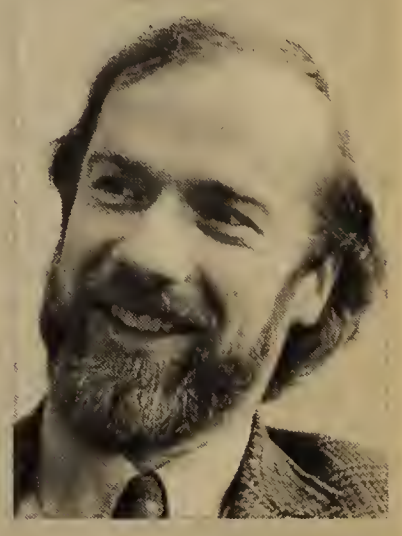
To test whether cannabis directly contributes to assaultive behavior, the team investigated drug use patterns among 248 males imprisoned in a moderate security facility during June 1963 to July 1975.

The youths ranged in age from 13 to 21 years and had used many different types of psychoactive drugs. They were representative of the most serious youthful offenders in California.

In one part of the study, 59% of 220 subjects reported one or more fights while under the influence of alcohol. Twenty-five per cent reported one or more fights under the influence of cannabis.

Of 229, 39% identified secobarbital as the single drug most likely to enhance assaultiveness.

Alcohol was in second place with 28%. Neither



Jared Tinklenberg

cannabis nor any other single drug was chosen by more than 5% of the subjects.

"Cannabis and alcohol again differed significantly. Conversely, cannabis was cited as the single drug most likely to decrease assaultiveness. No other drug was selected by more than 7% of the subjects. Cannabis and alcohol were significantly different."

Of the 84 who said they used drugs specifically "to bolster courage", 42% used alcohol, 20% used secobarbital and 16% used cannabis.

Asked to recall each fight they had had in the year prior to incarceration, 29% said fights had involved only alcohol and 2% involved only cannabis.

29 million Americans have tried pot: Bryant

(continued from page 1)

gets about it, whether it carries decriminalization, it's a question of degree."

Dr Thomas Bryant, president of the Washington-based Drug Abuse Council, and both a medical doctor and a lawyer, was also one of the final speakers.

He agreed with Mr Sonnenreich "most fervently when he said it's going to happen. Marijuana is going to be

Thomas Bryant

decriminalized de facto and by law."

He said it was a "terribly sad fact" that in so many states "we've got a law that is not supported or preserved".

He said a national survey by the Drug Abuse Council on marijuana use indicates 29 million Americans have tried marijuana at least once and more than 12 million of them use it regularly.

"If I had to make a prediction, I would think that within the next two or three years, more than half the states in this country will have moved legislatively to decriminalize marijuana. And I'm hopeful, because I think it's a move in the right direction, that the federal law will also be changed."

If the drug is decriminalized, it will also have to be distributed — possibly through government channels, suggested Dr Nancy Rubin in an interview with **The Journal**.

Dr Rubin was principal investigator on the Ganja in Jamaica study, an anthropological study of chronic marijuana use, (**The Journal**, September 1975), and is director of the Research Institute for the Study of Man, in New York.

"Once cannabis is decriminalized, the question is where do you buy, how do you buy? How do you have possession if there is no means of distribution?

"The whole thing is straddling the fence really. Allowing possession without providing for regulatory mechanisms of the content, the quality and amount that can be sold, and the price, is a chimera. And we're deluding ourselves if we think that one can be done without the other.

"This has to be done by government regulation as alcohol has been regulated and as tobacco is regulated. This could provide tax money for the government. The question of who should get the profits is a kind of loaded policy question: It's a capitalist society, a free-enterprise society.

"But, there has to be control of the content, of the purity, of the amount and, particularly, of the age below which the sale should be prohibited."

Distribution and control was a question also touched on by Dr Bryant.

"These are the kinds of questions that I think now have to be moved immediately to the agenda," he said.

In his address, Mr Sonnenreich suggested there has been "a sort of sigh of relief" on the cannabis question and is now "a sense that we're going to resolve this issue . . . not because marijuana is harmless, not because the use of the drug is good or bad but mainly because, from a policy point of view, we overstated the relative importance of this issue compared to other health issues".

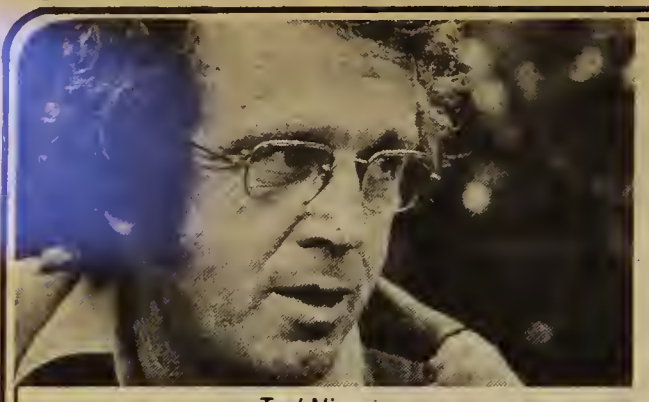
Looking at it from a scientific point of view, he said, it is a "tremendous object lesson for all of us on how not to get embroiled by using scientific research to prove political points". He said this has had a "devastating effect on the credibility of the academic community".

It should be recognized "there will be other 'drug problems' and perhaps this is the time to sit down and reflect upon what it is we should be doing with the other substances so that we can at least present government officials and policy makers with decisions that are informed before the fact rather than after the fact."

A reiteration is also needed, he said, on "what is this role of law when you're talking about the use and non-use of a drug or drugs.

"The problem we had and have with marijuana, and with many of these other issues, including alcohol, including tobacco, is that realistically a lot, or a significant percentage, of the population did not abide by the law. And when they don't, it is impossible to enforce."

The meeting, called by the New York Academy of Sciences, was jointly sponsored by the National Institute on Drug Abuse and the New York Medical College.



Ted Nissen

From 'helpee to helper' SPAN closes the gap

By Saul Abel

POMONA, Cal. — A rehabilitation program for ex-convicts and ex-addicts, directed by a man who does beautiful needlepoint?

Difficult to believe, but it's true.

The man is Ted Nissen, a 50-year-old Scots-American dynamo. The program is SPAN — Special Project Alcohol and Narcotics — a joint venture of the California Department of Corrections and California State Polytechnic University (Cal Poly).

"To my knowledge, SPAN is the only program of its kind in the nation; the role of the State Corrections Department, particularly, is unique," Mr Nissen told The Journal.

Located on the Cal Poly campus here, about 30 miles from Los Angeles, SPAN is designed to bridge the gap between prison and university, between the correctional world of delinquent behavior and the academic world of preparation for better citizenship.

From 1971 to 1975, SPAN was shaped as a demonstration-training project. Its goal was to train correctional inmate-addicts to work as paraprofessional "change agents" or catalysts in community service, helping to blend effectively the differing perspectives of ethnic groups, social agencies, and political and economic institutions in the community.

Mr Nissen believed SPAN trainees could improve services-delivery systems for special culture groups, the aged, the poor, and the former prison inmate, with special emphasis on alcoholics and drug addicts.

Officials of the Department of Corrections, where he was a unit supervisor and is now a district administrator, and of Cal Poly, where he was a part-time instructor, agreed with him.

So did the National Institute on Alcohol Abuse and Alcoholism, which supported SPAN with grants of almost $700,000 for the first four years of operation.

The basic approach at SPAN, Mr Nissen says, was to try to show the trainees "how the world really works".

Self-responsibility was expected; if a trainee relapsed into alcoholism or drug addiction, it was up to him or her to correct the situation or leave the program. Positive reinforcement, not negative, was preferred.

"We tried to impress the trainee that he was a pretty nice guy," Mr Nissen explains.

In the long run, the approach was effective, but in the early stages, SPAN had a stormy course. The project was first housed inside the prison, in Barracks 4 at the California Institution for Men at Chino.

The 10 men and five women in the first class enjoyed a startling degree of freedom — to argue and challenge, to learn, to associate with the opposite sex, and even to communicate with the outside world by way of a special telephone.

Trainees also received a stipend, in graduated amounts, of $1,100 each over the two quarters (six months) duration of the program.

As Mr Nissen puts it, Barracks 4 must have seemed a kind of "gingerbread house in a forest of hunger".

Though the trainees made progress in their group discussions, behavior modification, interviewing skills, community organization and social change, writing skills and group dynamics, the tensions built up.

The co-ed nature of the group was one disturbing factor. Another was the lack of genuine interest in SPAN goals by many trainees who were really playing a "get-out" game. Another was the presence of parole agents, which was expected to curb antisocial behavior, but turned out to have the opposite effect.

Finally it was decided to eliminate the prison phase of SPAN and shift the entire operation to the Cal Poly campus. The trainee selection process and the curriculum also were overhauled. Previously, trainee selection had placed much emphasis on leadership qualities. This produced an unmanageable roomful of prima donnas. Now the focus shifted to psychological tests and oral interviews.

To produce a more interesting and relevant curriculum, 21 "mini-courses" were developed, including the multi-determinant nature of alcohol abuse and the multi-model treatment of alcoholism; detoxification and rehabilitation, and standards for the recovery home; early, middle and late signs and symptoms of alcoholism and/or polydrug abuse; family dysfunction; political, social and economic forces acting upon the community-based program; emergency intake procedures, crisis intervention suicide prevention and medical emergencies, treatment models, techniques and personality theories.

Instructors were physicians, psychologists, law enforcement officers, judges, attorneys, researchers and other professionals. The SPAN setting was Kellogg Hall on the Cal Poly campus. Former home of William K. Kellogg of breakfast cereal fame, the rambling, tile-roofed mansion was surrounded by beautiful wooded hills.

The dramatic contrast between the stark steel and concrete prison environment and these newly decorated rooms, bright with colorful curtains, drapes and bedspreads — these made a difference in the way trainees chose to deal with their problems.

Gradually, a therapeutic community evolved, utilizing group therapy and confrontation. At first, staff conducted these sessions, but in time a group of stronger trainees emerged who began to assume responsibility for confrontation of their fellow trainees. This gave trainees a method of dealing with behavior problems without breaking the prison code or "snitching."

In all its activities, SPAN's approach was broadly eclectic. Mr Nissen and his staff did not hesitate to employ any technique, from systems analysis to psychological testing.

They used "gimmicks" like a mood record with which the trainee took his "emotional temperature" three times a day, and a "value wheel" adapted from a University of California, Irvine, concept and the Lasswell value scale developed by the Orange County, California, Drug Abuse Prevention Center.

Mr Nissen felt that addicts tend to lose their time sense, so activities were structured on a fairly rigid time frame. Videotape recordings and playback were freely utilized. An internship program sent selected trainees out to community agencies for practical experience.

In 1975, SPAN completed its first phase as a demonstration project with the primary goal of training correctional inmates, involved with alcoholism and narcotics addiction, who upon release would undertake new careers in community service.

A comprehensive report on the project entitled "A Span of Four Years" concludes that ex-felon ex-addicts *can* be trained as paraprofessionals in an academic setting without a high reversion to drug usage, and such trainees *can* be placed as effective workers in the mental health field.

SPAN statistics support these conclusions. Almost 90% of SPAN graduates have been employed by a social service agency, helping people with alcohol or drug problems. Among them are the American Indian Free Clinic, Martin Luther King Hospital, Orange County Mental Health Department, Bridge Back Drug Rehabilitation Project and Boy's Republic.

SPAN's retention rate increased from 20% for the first class to 87% for the sixth class. The recidivism rate among graduates was about one in nine, compared to a rate of one in two for the California prison population as a whole. Trainees were approximately 70% males and 30% females, ranging from 20 to 55 years of age.

The dollar-and-cents impact of the project was significant. One SPAN trainee and his wife were criminal addicts for many years, but both were employed in community service agencies after training. Costs of maintaining this couple during their prison terms, of supporting their children on public welfare, and of money and merchandise they stole to maintain their drug habit, totalled an estimated $856,000. This was more than the entire sum of grants to SPAN for its first four years of operation.

The start of SPAN's phase two was signaled by a one-year grant of $471,600 from the National Institute on Alcohol Abuse and Alcoholism and the National Institute of Mental Health. As an experimental training program sponsored solely by Cal Poly, entitled "New Careers in Community Service," the project offers 30 units of university undergraduate credit for the 6-month program of on-campus and in-community training.

Trainees are given 15 hours of classroom experience and 16 hours of directed internship involvement each week in addition to regularly scheduled homework assignments. A stipend, books and student fees are provided.

One salient change is removal of the residential feature. Trainees now reside in the community, commute to the university, and utilize all the other support systems that have been tested.

Another change is the composition of the trainee group. About half of the trainees are ex-felons. The other half are clients of the California Rehabilitation Department who have been involved with drugs or alcohol.

A control group of approximately the same number of ex-felons "out on the street" will be observed before, during and after the training period. These will not receive training, and will be compared for drug use, criminal offences and other pertinent parameters. Comparisons also will be made with the results of the former residential program.

The stated purpose of SPAN now is the training of ex-addicts, including ex-felons, in the prevention, intervention, treatment and rehabilitation of alcohol and drug abuse, in order to prepare them for jobs in human service. Or as Mr Nissen paraphrases it, "to turn helpEES into helpERS".

Looking back on SPAN's past, Mr Nissen says: "I think we have not only trained change agents, but we've produced an effective treatment model and demonstrated the tremendous potential economic savings to society."

Spiralling trend continues

Ontario alcohol sales rose in 1975

By Karin Sobota

TORONTO — New retail stores and increased revenue from liquor sales are the highlights of the 49th report of the Liquor Control Board of Ontario (LCBO).

The report, which covers the fiscal year ending March 31, 1975, states that sales of spirits, wines, and beers during the 12-month period amounted to $683,258,454, compared to 1974 sales of $594,438,726.

Taxes collected on the sale of alcoholic products through government stores was $392.5 million, an increase of $88.8 million (15%) over the 1974 fiscal year.

In addition to the 535 regular LCBO outlets in operation, 61 agency stores were operating in the isolated areas of northern Ontario. These include 21 self-serve stores and the three additional agency stores opened during the year.

"In keeping with the board's policy to have new outlets, relocations, and renovated premises designed as self-serve stores wherever possible, six stores were relocated and 19 stores were converted at their present locations to self-serve," the board's chief commissioner, General George Kitching states in the report.

Twelve new brewers retail stores were also opened during the year in addition to the 416 stores already existing.

Although sales increased overall, revenue from brewery gallonage fees and Ontario wineries decreased during the year because of new regulations under the Liquor Control Act.

In the past, brewery gallonage fees have been collected on the date of production. "But in order to conform with measures being taken by the federal government to exercise more economical control over the collections of taxes from the breweries, the gallonage fees are now collected on the date of shipment," the report states.

Reduced revenue from wineries was caused by removal of the 10½% fee previously collected through winery retail stores and later eliminated to encourage the Canadian wine industry.

Forty-two countries, including Canada, were represented in the LCBO's listing of 2,047 spirits, wines and imported beers.

BETTY LOU LEE reports from the joint annual meeting of the Royal College of Physicians and Surgeons of Canada and the Canadian Society for Clinical Investigation, held in Quebec City

In wake of teenage alcohol use

Increased pancreatitis predicted

INCREASED TEENAGED drinking in Canada may lead to a higher incidence of alcoholic pancreatitis in future years, a University of Ottawa gastroenterologist warns.

Dr Richard R. Gilles, associate professor of medicine, said teenagers account for much of the 80% increase in alcohol consumption in Canada since 1968, and alcoholic pancreatitis is age-related.

While cirrhosis of the liver develops at the average age of 53 among those who started drinking after the age of 30, pancreatitis begins at an average age of 38 among people who began drinking about 20.

Dr Gillies was part of a panel on alcohol and the gastro-intestinal tract at the meeting of the Royal College.

Dr Henri Sarles, professor of gastroenterology, Faculty of Medicine. Marseilles, France, and a specialist in pancreatitis, said the death rate from the disease in Marseilles is four per thousand, and 80% to 90% of this is due to alcoholism.

Drinking patterns also have an effect on the type of pancreatitis one develops. Those who drink the same amount of alcohol every day are more prone to the chronic type of the disease. Those who go on weekend benders are more prone to the acute variety, which can often be fatal. "It's one of the first causes of sudden death in Norway," said Dr Sarles.

He noted that throughout the world, consumption of meat and fat was higher among patients who developed pancreatitis.

He described the toxic limit for both the liver and pancreas as more than four drinks a day for men, and half that for women. In Europe, where women drink less than men, when they do develop pancreatitis it's after 11 years of drinking, rather than 18 for men.

To Dr Sarles, alcoholism is a political, not a medical problem, and his solution is to shut down the big international firms that produce alcoholic beverages.

"It has been proved that consumption is proportional to production, and the only solution is to reduce production .... Price doesn't modify consumption .... In some African countries, as soon as the whiskey factories are built, consumption goes up immediately."

Dr Ivan T. Beck, professor of medicine at Queen's University, Kingston, said it is "astonishing how much is known on the effect of alcohol on the liver, and how little is known about its effect on the small intestine".

It appears that acute intake of alcohol interferes with absorption of glucose and amino acids, but increases fat absorption. On the other hand, chronic intake depresses absorption of fat, glucose, thiamine, folate, vitamin B12 and possibly calcium.

"It's just as harmful to the small bowel as it is to other organs, but people don't die from small intestine disease," said Dr Beck. "In chronic alcoholics, we see changes in small bowel cell structure like those in the liver." They appear to be reversible after long periods of abstention.

In the stomach, there are acute cellular changes after ingestion "but whether there are chronic changes is still to be settled". Alcohol damages the cellular barrier that prevents digestive juices from acting on the stomach lining.

"This barrier has an amazing ability to renew itself, and it does so quickly, but in many cases (with alcohol) it loses this ability, and then you get erosion of the lining."

Dr Beck said 30% of the patients in his 18-bed gastro-intestinal unit are there because of alcohol-related disease: gastritis, malabsorption, hemhorrages, cirrhosis and pancreatitis.

"Some of them are in terrible shape, and they are the most expensive patients on the unit to treat. Some of them are on hyperalimentation that costs $50 a day in itself."

If alcohol consumption can't be cut, and he admitted this couldn't be done easily, he thought research might concentrate in a few areas of preventing its damage. One would be to establish the limits on how much can be drunk without major damage. Another would be to determine whether it is ethanol itself or other constituents of alcoholic beverages that cause damage. A third could be the possibility of adding something to alcoholic beverages that would prevent damage.

Pot and penicillin G do not mix

PENICILLIN G should not be given to marijuana users, a Laval University group has concluded after experiments in which the combination caused epileptie seizures in dogs.

Dr Pierre Morin, head of the research centre at Hôpital Laval, says pot-smoking appears to interfere with the blood-brain barrier that normally prevents penicillin from getting to the brain.

In an interview with **The Journal** during the CSCI meeting, he said there was no reason to believe this barrier was any different in humans than it is in dogs. In both species, when meningitis breaks down the barrier, administration of penicillin can cause convulsions.

Even one marijuana cigarette resulted in jerky movements and an epileptic pattern on the electroencephalogram after the dog reeeived penicillin.

"It's the first time this door has been opened, the first indieation that the barrier becomes permeable," Dr Morin said, adding that the results lead to more questions than answers.

The convulsive reaction appears to be dose-related, but there is no indieation how long the barrier permeability lasts, or if it at some point becomes irreversible. All the test dogs were killed so their tissues could be examined.

It is not known if other drugs, such as LSD, could have the same effeet, but Dr Morin's warning about penicillin use was extended to all users of illicit drugs. He also urged caution in the use of other medieations known to be epileptogenic in this group.

Dr Morin said he was particularly concerned that chronic drug abusers who attended venereal disease clinics would be treated with penicillin G, the drug of choiee in VD infections.

The research also brings up the possibility that other normally therapeutic drugs might be potentially harmful if given to pot smokers.

The smoking dogs were of two groups. Chronic smokers received four cigarettes daily for 10 weeks through a tracheostomy tube. On the day of the tests, they smoked eight cigarettes. The acute smokers got cigarettes only on the day of the tests. A group of control animals was also tracheostomized and hooked up to electrocorticograms.

Two doses of 375,000 IU/kg sodium penicillin G were administered intravenously at a 20-minute interval in all animals. One of five control animals showed oceasional jerks in the limbs, but the autopsy showed no pathological changes.

Four of the five acute smokers showed muscle jerks, and the fifth clonic movements. The electrocortiocograms showed none of the smoking dogs was unaffected.

"Ninety minutes after the last injection of penicillin, epileptiform waves appeared spontaneously and formed spindles lasting five to six seconds. These complexes were still present spontaneously at 120 minutes, although their duration was becoming shorter — three seconds instead of six," said biology student Sylvie Halle who presented the paper.

"It should also be noted that immediately before or after the epileptiform waves, the tracing was desynchronized. This observation holds for all the animals that smoked marijuana, either acutely or chronically," she added.

The smallest animal in the chronic smoking group suffered 13 grand mal type convulsions in 2½ hours. Typical grand mal seizures in the dogs started 88 minutes after the last injection of penicillin, and lasted 112 seconds.

Dr Morin noted that routine EEG tracings will not give any warning of a change in the blood-brain barrier, and cannot be relied on for this purpose.

Time and resources are wasted on toxicologic analysis of ODs

ROUTINE TOXICOLOGIC analysis in cases of acute drug overdoses in adults doesn't yield much in the way of useful information, and is adding unnecessarily to health eare costs, says a group that studied 1,749 cases in a three-month period in 21 Metro Toronto hospitals.

"There is no evidence that costly toxicologic analysis is efficiently requested by treating physicians, or that it contributes significantly to a decrease in morbidity and mortality," Dr S. M. MacLeod told participants of the Royal College meeting. He is assistant professor of medicine and pharmacology at the University of Toronto.

Seventy per cent of the 1,749 cases had at least one analysis, with 5,380 tests of blood, urine or gastric contents. But only 25% of the samples provided any positive or interpretable result.

"When there is a history of alleged drug overdosage or aeute drug ingestion, approximately 10% of the samples will contain all of the drug allegedly taken. We contend this pattern of sample submission reflects relative nonselectivity on the part of the treating physician, and constitutes a major waste of physical and human resources," Dr MacLeod said.

The study, done in the first quarter of 1975, is part of a larger, continuing project undertaken by the joint Division of Clinical Pharmacology of the Addiction Research Foundation Clinical Institute and Toronto Western Hospital.

About 80% of the patients in the study took intentional overdoses, and benzodiazepines topped the list of substances. They were involved in 574 cases, and alcohol in 547, although cases of simple alcohol abuse were excluded from the study.

"Barbiturates, which for many years were the prime agent of overdosage, have fallen to the point where they are seen in only 13% of our patients (230 cases). This reflects their decreased popularity as therapeutic agents," said Dr MacLeod.

Almost half the patients had taken two or more drugs, "with ethanol being the commonest fellow traveller". About one-third combined the benzodiazepines with alcohol.

Dr MacLeod noted that many of the drugs taken appear in blood in very low concentrations, yet serum accounted for 69% of the tests. In benzodiazepine analysis, only 0.5% were positive, and confirmed the clinical diagnosis in only 7% of cases.

Co-authors were Dr E. M. Sellers, head of clinical pharmacology at Toronto Western Hospital; Howard Kaplan of the ARF data processing section, and Cheryl S. Stapleton, head nurse monitor at the ARF and Toronto Western.

Caffeine tried in newborn babies

Some 'forget to breathe'

QUEBEC CITY — Caffeine, the universal eye-opener, is now being tried to keep some premature babies breathing.

Preliminary results are promising, after tests on 17 babies at Montreal Children's Hospital who had periods of apnea when they seem to forget to breathe.

Dr Jacob Aranda of McGill University, director of the neonatal research unit at the hospital, says caffeine has been used only when all other methods fail, because its possible effeets aren't known. Standard techniques are flicking the babies' heels, increasing the oxygen supply, or negative-pressure respirators.

"Apnea was reduced in all 17 babies, and eliminated in some," Dr Aranda said. "The babies were a little more awake, they breathed better, and their respiratory rate increased significantly."

The group found in premature newborns, the half-life of caffeine can range from 36 to 144 hours, compared to four hours in the adult, so care must be taken not to cause excessive stimulation to the central nervous system. The babies were given the caffeine equivalent of one-fifth a cup of coffee once every two to three days, either orally, intravenously or intramuscularly.

Because 98% of babies have significant levels of eaffeine in their cord blood at birth, there is a temptation to speculate that caffeine withdrawal may be a factor in apnea, but there is no data to support this, Dr Aranda said.

Apnea usually appears three to four days after birth, and stops at about four to six weeks.

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Decriminalization... a matter of time

IT'S A QUESTION of time. Not, *shall* we decriminalize marijuana, but to what degree do we decriminalize?

Already, several jurisdictions in the United States have reduced penalties for pot use to traffic citation status — as in the Oregon model. This is still one step removed from legal use, but the taking of that step clearly shows a trend in public sentiment.

Despite evidence that cannabis use involves some medical risks, the laws are changing. They are changing because society is forcing a change. As in so many cases, first the practice, then the politics.

Are we going to prepare for the consequences?

Are we prepared to consider state and provincial boards to control and regulate concentration, purity, and distribution of this drug as we have with alcohol?

Can we afford not to do so?

Will we remain content to divert the individual user into clandestine, unregulated, potentially dangerous supply sources?

Wouldn't it be easier to guard against distributors selling to children by regulating the distributors?

Can we expect governments, seeing the drug sold anyway, to withstand the temptation of laying their hands on potentially large revenues? Everything else is taxed, why not pot?

Such questions will have to be considered before long. It would be irresponsible to approach them casually. And it would be tragic if we allowed ourselves to get bogged down in the same diversions and distortions that have characterized so much of the 20th century marijuana debate.

In the past, many scientists have opted for the battering ram approach to decision-making about pot. They have allowed themselves to be split into "pro" and "anti" marijuana camps. Advocates of one or the other political hue have jumped upon each small piece of scientific data to claim it as final and conclusive evidence that marijuana is either harmful or not harmful and should be opposed or approved.

There has been much damage done to the credibility of the academic community as a consequence of this polarity, as Michael Sonnenreich points out (Page 1). Too many value judgements have been passed off as science.

Let's learn from that.

In considering some of the forthcoming issues we would do well to realize the limitations of science in a debate that involves life styles and social values.

As the Kalants put it in their book *Drugs, Society and Personal Choice*: "Science can discover facts concerning the acute actions of drugs . . . the consequences of prolonged or heavy use . . . the extent of use, the factors which determine this extent, and the probable consequences of change in these factors.

"However, decisions as to whether these effects or consequences are to be considered good or bad and how society should react toward them fall not in the area of scientific fact but rather in the fields of personal and social values, ethics, and political feasibility."

Of course, the social scientist can give us clues about the expected prevalence of use should we decriminalize, or about the kinds of control measures that would work best; and the biologist, pharmacologist, or psychiatrist can tell us what has been observed so far in terms of the extent to which marijuana causes physical or psychic damage. But we ought not expect more.

In terms of making decisions about the role of drugs in our lives, scientists can't bail us out. Nor can doctors.

Whether we want to regulate marijuana, whether we want our children to use it, whether we want its quality, concentration, and distribution controlled, are political and social decisions.

The fact is that, in the US at least, marijuana is being decriminalized. Despite some pretty sound evidence that the drug can't be good for anyone's health (just as tobacco and alcohol can't) and that it might, in fact, be harmful, decriminalization is taking place.

This isn't irrational, it just shows that medical criteria aren't the only ones that matter in a society that puts a high premium on personal freedoms and self indulgence.

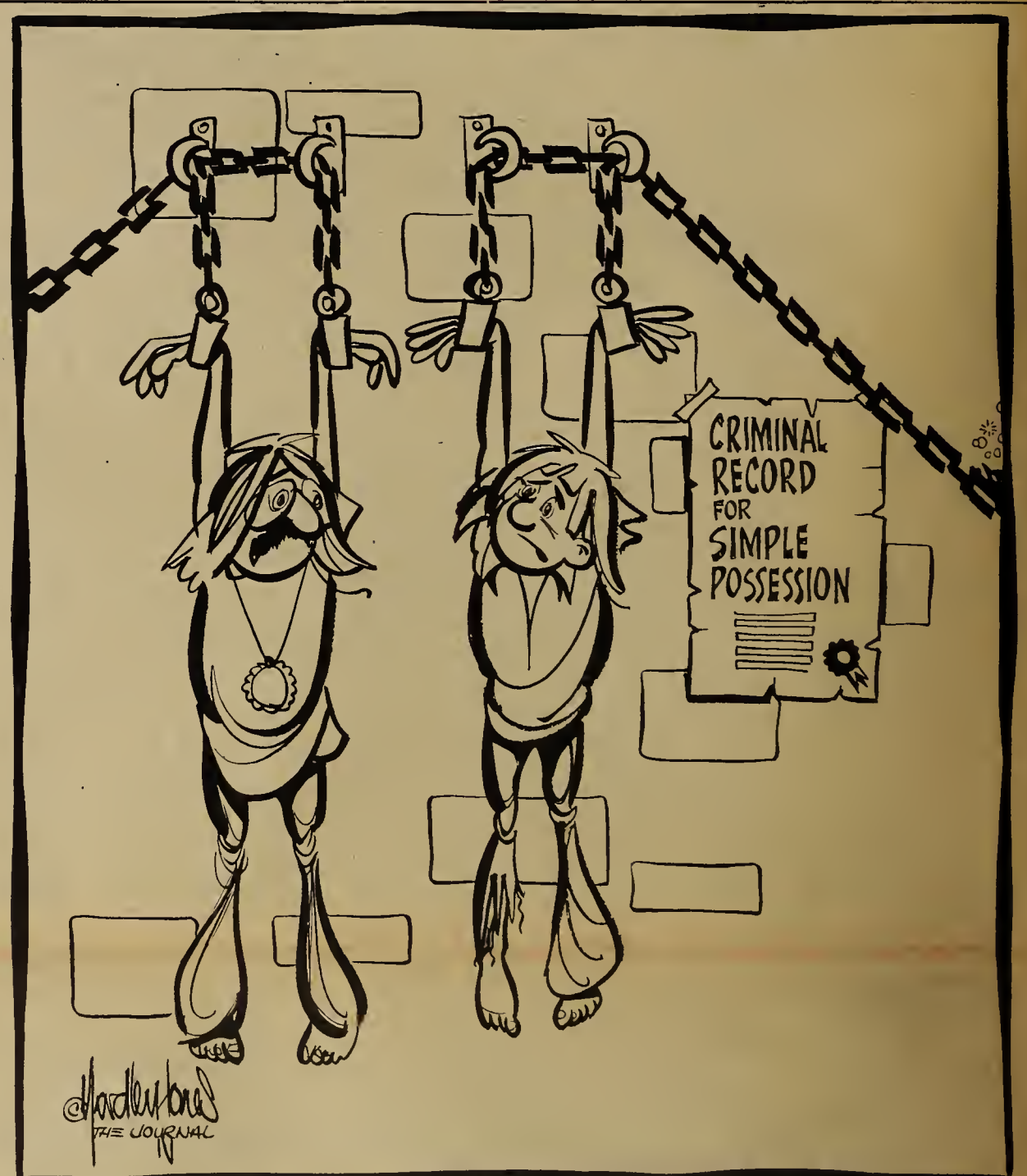
Six states have moved on their own. Canadian legislation now pending suggests that this country will move in a similar direction. Perhaps not to the same extent, but in the same direction.

Apparently, large numbers of people feel more threatened by existing laws than they do by the medical risks.

Decision made.

The question now: How much imagination and initiative can we show in setting up control systems that will keep these risks to a minimum?

— Milan Korcok



"Trouble is, when cannabis eventually gets decriminalized — we won't"

Letters to the Editor

More letters — page 12

Alcoholism in the family

Sir:

"Researchers have ignored women" is the heading of the article in the November issue of **The Journal**. It deals with the alcohol and drug abuse problems of women.

This is not the most basic area of neglect by researchers as related to women. Far more women are injured by marriage to an alcoholic husband than by alcohol abuse themselves.

Margaret Cork's excellent book *The Forgotten Children*, indicates the very real damage to children who have an alcoholic parent or parents. At least half of these children are girls who carry this hurt into their adult life.

There are also mothers of alcoholics and sisters of alcoholics.

Seventeen years of professional work in alcoholism and an additional 23 years as a clergyman indicates to me that the most neglected area of research is the family of the alcoholic, especially the spouse of the alcoholic.

Alcoholism has roots in the family of origin and feeds on the nuclear family system. Yet I find no basic research on how the family becomes the counterpart of the illness, or what the family needs in protecting itself from damage and in promoting recovery of the alcoholic.

There are two key persons who can intervene and turn the alcoholic in the direction of recovery; the spouse and the boss. Industry is learning how to motivate recovery with benefits to itself as well as to the alcoholic.

Is it not time we did some basic research on the wife of the alcoholic, how she fits into the syndrome of alcoholism, what her needs are and the mutual benefits to herself and her alcoholic husband when she is given adequate understanding and help with her problems as related to alcoholism?

Joseph L. Kellermann
Alcoholism Information Ctr.
Charlotte Council
on Alcoholism Inc.
Charlotte, North Carolina

Alcohol costs

Sir:

There can be little doubt that lowering the drinking age to 18 years has not only created numerous social problems and increased insurance rates, but has also added to Ontario's already skyrocketing health costs of $3 billion. Nutrition Canada's $2.5 million health survey revealed that ONE THIRD of our medical costs go to cover malnutrition, a large percentage related to the effects of alcohol.

While highway accidents have more than doubled for drivers between the ages of 16 and 19 since the lowering of the drinking age, the real problem yet to be faced is the monumental one of alcohol-related disease.

While parents, sociologists, psychiatrists and politicians ponder the government's decision in lowering the drinking age, the real and unseen damage is being done to the brains and bodies of teenage drinkers. The tragic death of a 14-year-old Toronto schoolboy after drinking 13 oz of whiskey is only one visible sign of the damage being done.

Alcohol is a poison to the body. A recent Gallup poll in the US found the majority of people believe students have "too many" rights. Prime Minister Trudeau has been assailed for his permissive society. Parents have been blamed for the action of their children because

(continued on page 12)

Backgrounder

RENO, Nevada — In the care and handling of drug abuse patients, physicians have often been criticized for their negative attitudes, or their pessimism about the outcome of treatment.

Dr Morris Chafetz, former head of the National Institute for Alcohol Abuse and Alcoholism once reported that physicians in a teaching hospital avoided the early diagnosis of alcoholism and tended to wait until the patient fit a derelict stereotype.

Others have noted that both psychiatrists and psychologists considered treatment benefits for alcoholics to be very limited, and were reluctant to become too personally involved in providing treatment.

In response to such concerns, the American Medical Association called in 1972 for "high priority to be given to pedagological methods which will encourage the medical students to sort out their personal experiences and subjective feelings, and attain the goal of personal objectivity."

Changing such attitudes, particularly via the classroom, has remained an elusive goal. But recent experiences of 48 second-year medical students at the University of Nevada in Reno show a well-structured course in drug abuse can do more than just pass on bits of information: It can change the way a physician regards his patient, and in turn strengthen the chances for better quality care.

The course, supported by the NIAAA and the National Institute for Drug Abuse (NIDA) career teacher program, was developed by Dr John Chappel, professor of psychiatry at Nevada. It consists of 28 hours — one full week of instructional time at the "end of the central nervous system block", in the second half of the sophomore year.

The course involves each student, in an experiential way, with different aspects of drug abuse. It uses videotape patient interviews, clinical problem-solving, and small group discussions. Each student is also assigned an Alcoholics Anonymous sponsor who takes him to an evening meeting prior to field trips to other treatment programs.

The course also covers the history and epidemiology of drug abuse; management of overdose and withdrawal; medical complications; psychological, cultural and legal aspects of drug abuse; treatment methods; detection technology; the role of the physician in treatment; physician susceptibility; and prevention mechanisms, and includes interviews with basic and behavioral scientists.

The allocation of so much time to alcohol and drug abuse education within the "required" portion of the curriculum is rare.

"So far as I know," says Dr Chappel, "I have more required — not elective — time for undergraduate medical students than any other school in this country or Canada.

"Many places have a lot of elective time, but I have that one solid week," he says.

If pre-and-post-test evaluations of the course are any indication, that week is doing a lot in terms of helping students develop more positive attitudes toward their drug abuse patients.

Evaluations have shown, overall, that students feel far less hesitant about encountering drug abusers after the course than they did before.

The most pronounced attitudinal shift among the students was in respect to users of hard drugs (heroin, cocaine).

In effect, students were far more willing to become involved in the treatment of hard drug users, and were more encouraged about the treatment prospects.

Although this postive attitudinal shift was most pronounced in respect to hard drug users, it was clearly discernible in respect to alcoholics and users of soft drugs (barbiturates, amphetamines, marijuana). The shift was very slight in respect to compulsive smokers and obese overeaters.

Following the course, the students felt the greatest treatment potential lay with self-help groups such as AA, Synanon, and Weight Watchers. Even before the course, these treatment modes were ranked highly by the students, but the course clearly accelerated their support.

The potential value of job counselling as a rehabilitative mechanism rose considerably in their esteem as they progressed through the course.

Students also seemed more optimistic about the role of family involvement in treatment, about individual counselling, and about chemotherapy.

Following the course, students saw the physician's role as being more critical to treatment of drug abusers or alcoholics than they had first perceived. They also ranked their own professional roles as physicians higher than those of the profession generally. In effect, they had become more optimistic about what they had to offer the drug abuse patient.

Changing physicians' attitudes to drug abuse patients remains an elusive goal. But the University of Nevada appears to be making some important gains, as **The Journal's** *Contributing Editor, Milan Korcok, recently learned.*

Pre - and - post - test mechanisms were also used to define relationships between the drug use experience of the students themselves and their own attitudes toward their drug-using patients.

Dr Chappel points to some provocative findings in this respect. For example, students who used drugs frequently (at least two to four times a week) appeared to become more receptive to the prospect of working with drug abusers, and more optimistic about the physician's role in treating alcoholics, hard drug abusers, soft drug abusers, and obese overeaters.

Among the 89% of students who reported using some alcohol, frequency of drinking did not seem to have much effect on attitudinal change.

But, among students who used no alcohol, there appeared to be a "negative" attitudinal shift: After the course, they felt the physician should have less responsibility in treatment of the drug abuser.

This was a "puzzling and disturbing" finding, says Dr Chappel.

They may have felt that they would refer patients to treatment programs rather than attempt to treat the drug dependence themselves.

"I was disappointed in this response. What I had hoped would come about and what I emphasized in the course was that the physician has a responsibility and he can play a significant role. Simply referring a person into a treatment program does not mean the end of that responsibility because most treatment programs do not provide the necessary medical care," says Dr Chappel.

However, only 11% of the 48 students claimed to be non-drinkers. The majority indicated they were willing to accept more responsibility for their own involvement in the treatment process.

Bolstering the student's enthusiasm for treating the alcohol and drug abuser within the academic environment is important, says Dr Chappel.

"My experience indicates students' attitudes toward alcoholics become increasingly negative as they progress through medical school."

Inside Science

THIS MONTH The Journal introduces a new column.

***Inside Science* will be written by scientists and researchers who will describe particular aspects of, theories on, or approaches to, various areas in the field of addictions.**

To begin this monthly series, Dr Ruth Segal of Toronto discusses treatment of narcotic dependence with antagonists.

By Ruth Segal, PhD

METHADONE IS currently the most extensively-funded and widely-used approach to the problem of narcotic dependence.

Although it has aided many individuals to lead more stable lives and eliminated their need to resort to crime to maintain their addiction, methadone substitution has been an over-simplified and inadequate solution.

The recent development of potent and safe narcotic antagonists has provided the basis for a different and effective model for the treatment and prevention of opiate dependence. Since narcotic addicts are a heterogeneous group, they require differential diagnosis, treatment, and criteria, to determine the most appropriate treatment modality for each patient.

Narcotic antagonists are compounds that block the euphoric and physiologic effects of narcotics; they are not addicting or habit forming and have no abuse potential or blackmarket value. After narcotic antagonists were found to block the euphoric effects of narcotics and prevent the development of physical dependence, Wikler in 1965 and Martin in 1966 suggested that they could be useful in the ambulatory management of abstinent narcotic addicts.

For this purpose, an antagonist had to be found that was effective when taken orally and could block the euphoria and dependence-producing effects of heroin or other narcotics for a sufficiently long period between doses, preferably for 24 hours or more.

Following these early suggestions by Martin and Wikler, clinical trials were pioneered by Jaffe at the Albert Einstein College of Medicine; Freedman, Fink and Resnick at New York Medical College; and Kleber at Yale University.

At present, the narcotic antagonist, naltrexone, appears to show the most promise. It can block the effects of a narcotic up to 72 hours, can be taken orally, and blocks the euphoric and dependence producing effects of narcotics.

The individual who receives a narcotic antagonist is protected against narcotic addiction. Even if he uses a narcotic, there will be no euphoria and dependence will not develop. With this protection, the patient can remain in the community where rehabilitation can take place despite the endemic presence of heroin and other narcotics.

Antagonists can be discontinued easily and without physiologic difficulty whenever rehabilitation reaches a point where medication is no longer necessary. Should the patient be tempted to use opiates again, as during times of stress, he can be put back on the antagonist and thus be protected against another failure. They are not appropriate for all narcotic users but they offer unique benefits to some of those being treated and can be used in a variety of ways.

When a narcotic antagonist is given to a subject who is physically dependent on narcotics, the antagonist will precipitate signs and symptoms of narcotic withdrawal (abstinence syndrome) and when used in this way can be a useful tool in the diagnosis of physical dependence to narcotics. If the person is not narcotic dependent, the narcotic antagonist will cause no reaction.

There are several other potentially valuable applications of narcotic antagonists in the treatment of narcotic dependence. One is a transitional treatment for individuals detoxifying from methadone treatment programs.

This use stems from recent recognition that a secondary abstinence syndrome (protracted abstinence) may emerge after detoxification from methadone and contribute to relapse. Early reports from patients who have been treated for this purpose indicate that naltrexone relieves symptoms occurring during this period. These reports are being investigated. The antagonist can be discontinued easily when it is no longer needed. The physical discomfort anticipated by patients planning to detoxify from methadone often interferes with their being able to take this step or to deal with the significant emotional factors associated with being drug-free.

Another advantage of antagonist treatment is the ease with which patients can resume taking medication whenever this additional support is needed, as in response to acute stress. A patient who feels he may not be able to resist using narcotics or who has begun to use them again after being medication-free for a time, can thus avoid re-addiction and failure. The knowledge of the easy availability of this protection is reassuring to the patient.

Antagonists are also particularly valuable because they can be used for prophylaxis. They can be given to sporadic opiate users who have not yet developed a physical or psychological dependence to prevent occasional use from being reinforced and ultimately conditioned.

They can also be used for people with a history of narcotic dependence who are being released from correctional institutions. The antagonist may be a useful tool to be used during transition from institution to community when susceptibility to relapse is high.

The antagonist may also prove to be of benefit to people attempting to remain narcotic-free who are not users of heroin or other illicit narcotics. This group may include dependence-prone professionals such as nurses or doctors and community people who obtain their narcotics through licit channels.

Clinical studies designed to identify criteria or typologies that can be applied in selecting the most appropriate treatment modality for an individual patient are necessary. At this point it appears the most important element for successful treatment with narcotic antagonists is motivation. Further research will provide more information about what types of dependent persons will benefit most from this treatment.

It should be emphasized that narcotic antagonists should not be seen as replacement for methadone. Methadone will continue to be a useful tool for a person who is physically dependent and for whom abstinence is not a realistic goal at that time; whereas the antagonist is appropriate for the abstinent narcotic addict who is trying to maintain a nareotic-free state.

Ruth Segal is acting joint program head, Narcotics Dependence Program, Clinical Institute of the Addiction Research Foundation of Ontario

Drug fears haunt Mexicans

By Thomas Land

GENEVA — Improved coordination of law enforcement throughout Mexico and Latin America have failed to reduce the volume of narcotics smuggled to the lucrative black markets of the North.

South America is also the source of all cocaine entering the illicit international channels, and of some of the cannabis (particularly from Colombia) destined for the North American markets. And it remains a staging point in the illegal traffic of drugs between Europe and North America.

A report by the United Nations' International Narcotics Control Board, issued in Geneva, reviews the current efforts of the Mexican Government to eradicate the opium poppy and the cannabis plant. Enforcement services there have recently dismantled several clandestine laboratories manufacturing heroin and have also scored several spectacular successes in the arrest of major international traffickers carrying more than 150kg of cocaine — almost the equivalent of the total quantity seized in 1973.

The board reports the Mexican authorities are planning to strengthen drug control laws and have already developed improved cooperation with enforcement services and customs departments of neighbouring countries.

"All these methods are very positive," the board comments. "Nevertheless, drug abuse would appear to be spreading, particularly along the frontier with the United States.

"Since experience shows that in the countries where illicit production exists it often leads sooner or later to a contamination of the (local) population, the board is sure the Mexican authorities are giving this matter the most serious attention.

"Furthermore", the UN report politely emphasizes, "in view of the large quantities of heroine, cocaine and cannabis, of Mexican origin or transiting through Mexico, which are supplying the vast illicit market in the United States, it is essential that the authorities should increase their efforts still more."

Drug abuse is a continent-wide problem in Latin America. Apart from the exclusively Andean phenomenon of coca-leaf chewing, the use of cannabis is particularly widespread and the use of psychotropic substances is on the increase, specially in Argentina and Brazil.

Over-production of coca-leaf persists in Bolivia and, while chewing absorbs a large proportion, the remainder is converted illegally into crude cocaine near the production areas.

The authorities are currently studying the feasibility of crop substitution schemes in order to reduce the cultivation of the coca-bush. But this would be an ambitious undertaking requiring a sustained effort on the part of the governmental authorities, the board observes, as well as considerable and continuing foreign assistance.

Six Latin American countries — Argentina, Bolivia, Brazil, Chile, Paraguay and Peru — have come together in a search for a regional solution to their common drug abuse problem. They recently held a conference which, the board comments, "should help to improve narcotic drug control in the region as soon as the resolutions adopted are implemented".

Discussing the annual disappearance of a high proportion of the coca-leaf production in Peru, the board urges a thorough examination of the entire system of production and control "so that the national authorities themselves may have a clear picture of the situation. It is . . . difficult to see how there can be any appreciable improvement as long as the cultivation of the coca-bush is still practised on so vast a scale."

Around th

Foreign happiness

Zambia's Department of Cultural Services wants to end the foreign habit local beer drinkers have adopted of clinking their glasses and saying "cheers". A program aimed at reviving the country's customs encourages its officials to "take measures to stop Zambians from using foreign ways of showing happiness when drinking in bars".

Cancer agents

A Mexican conference recently heard that marijuana contains a higher concentration of possible cancer-causing substances than does smoke from normal cigarette tobacco.

Nosy reporter

Ecuador's junta rulers have ordered a United Press International reporter to leave the

Sociology of drug abuse

UN appeals for worldwide effort

GENEVA — The United Nations' International Narcotics Control Board has made a worldwide appeal for intensified support of informed discussion and research into the causes and sociology of drug abuse.

In its annual report issued in Geneva, the board declares: "It is now universally recognized that the main obstacles in the campaign to eliminate drug abuse are the supply of drugs — in other words illicit production and manufacture — illicit demand, and the traffic which meets that demand. It is the demand, however, which raises the most complex problems, since its causes are the most difficult to identify and the remedies for it have not yet all been found.

"It is therefore more important (now) than ever to continue research on the aeteiology and sociology of drug abuse. It is true that some progress has been achieved and that certain causes of drug addiction have been identified; but they inevitably vary from one region to another and even from one social group to another within the same society. They also differ from individual to individual, and for each of the substances which lends itself to abuse.

"Measures to be taken in the field of treatment, prevention and rehabilitation must therefore take account of specific situations, and it is for each country to determine which of these measures are most appropriate to its own situation. International exchanges of information on the experiences gained and techniques developed would permit all countries to benefit from the research results achieved by each."

The board emphasizes, however, that attempts to acquire a better understanding of the problems related to demand are not sufficient to mitigate its most devastating effects. The campaign against the illicit traffic also calls for sustained practical action.

"Staff must be reinforced," the board urges, "and the resources devoted to enforcement must be increased; and it is also necessary to display greater determination and to develop national, regional and international cooperation.

"Moreover, in the regions which produce the agricultural raw materials used for the illicit manufacture of narcotic drugs, it is only by a stronger national will and greater international solidarity that these problems will be lessened and, in time, gradually eliminated."

After the wave of drug addiction in the 1960's, many governments have considerably increased their efforts to tackle the problem. But the board fears the world has grown accustomed to living with the drug problem and many countries may be tempted to relax their vigilance.

Indeed, the report makes a pointed reference to several unnamed countries said to be contemplating the legalization of poppy cultivation if only to avoid embarrassment to governments which must admit they are unable to prevent it.

"Such an initiative would aggravate the situation," says the board, "both at the national level, because of the risks of an increase in addiction, and also at the level of the international community, because of the risks of an increase in the international illicit traffic.

"The board therefore strongly urges the governments of these countries to abandon any such plans for economic, social as well as legal reasons . . .

"Effective control of the production of opium calls for special techniques and procedures which the present producing countries authorized to produce for licit export have taken a long time to develop; and even in these countries there are still cases of diversion to the illicit market. The impossibility of exercising effective control would be bound to operate to the advantage of illicit traffickers and the action required to deal with the resultant increase in the illicit traffic would also place a heavy burden on the national police forces and customs authorities, and would raise international protest."

UK hospitals get scorched by cigarette vendors

LONDON — Anti-smoking campaigners have found that stopping the sale of cigarettes to patients in British hospitals can be an uphill fight.

It has even led to one strike.

In a hospital in Scotland cigarettes were banned from the trolleys brought in by private traders who go around the wards selling candy and reading matter. Within two weeks, the sellers said their profits had fallen so drastically that unless they could return to selling cigarettes they would refuse to enter the hospital.

Hospital officials had to give in.

Delegates reported more success in dealing with voluntary organizations which operate small shops in many other hospitals.

World

country as an "undesirable" tenant. The reporter's abrupt withdrawal from the country came after he asked about a reported intervention by Vice Administrator Alfredo Povedo to protect a narcotics dealer from arrest.

Help, not hurt

Chronic alcoholics need help, not imprisonment, says the Police Superintendents' Association of England and Wales. The association states: "These people need help more than most and the thing they need most is a roof over their heads." Unfortunately, say the superintendents, resources available for chronic alcoholic are "totally inadequate".

Love that vino

Italy is once again the international frontrunner in wine consumption, having consumed 29.2 gallons per capita in 1974. Italian drinking habits, however, reached a peak in 1968 with per capita consumption recorded at 30.6 gallons. The French are not far behind Italy's number one position, having quaffed 27.21 gallons each in 1974.

Drink/drive

A new law on drinking and driving in the Netherlands sets a revised legal limit for drinking drivers of 50 milligrams of alcohol per 100 millilitres of blood. Police may now stop Dutch motorists at random and on suspicion of drinking call for a breath test. The law also allows a policeman to prevent a motorist from driving on, and even to stop someone about to drive if he seems to have been drinking.

It's elementary

Australia's alcohol educators are taking little comfort in the results of a recent survey of more than 3,000 students in grades six through 12. While one-third of grade-six pupils believe alcohol is a potential danger to their health, only 2.7% of grade 12 students think along the same lines.

Finland slows down

The state alcohol monopoly of Finland, known as ALKO, is starting a new drive to encourage the use of milder alcoholic beverages and restrain over-all indulgence.

Although thirsty Russians have a penchant for soda water, which sells in Moscow street vending machines, their continued preoccupation with alcohol has officials worried. Soviet officials have intensified efforts in educating the public about alcohol abuse, and enacted a series of penalties and fines for those who disobey increasingly stringent liquor laws.

New USSR alcohol data

Teenage use abounds

By John Dornberg

MUNICH — For the second time in the past three years the Supreme Court of the Soviet Union has held a "plenary session" devoted exclusively to "intensifying the struggle against alcoholism and alcohol abuse".

Top jurists from all over the country and supreme court judges from each of the USSR's 15 republics attended the meeting in Moscow to listen to reports and participate in discussions about the Soviet Union's current anti-alcohol drive.

The meeting, publicized at length in Soviet media, provided unusual insight and divulged rarely available information about the scope and extent of alcohol abuse in the USSR and measures being taken against it.

Thus, S. I. Gusev, deputy prosecutor general of the USSR, told the group that in 1974 more than 600,000 motorists were brought up on various charges of operating a vehicle while intoxicated.

The figure refers not only to accidents with property damage, personal injuries or loss of life but to simple violations of the traffic rules. Mr Gusev indicated those caught represented only a fraction of the motorists who drive while under the influence of alcohol.

(The USSR currently has about three million privately registered cars, about two million registered by firms and government agencies, and some three million trucks in operation.)

R. A. Simson, chief justice of the Estonian Republic Supreme court, reported since implementation of the 1972 law restricting the outlets and hours of sale for hard liquor, there had been a 16% reduction in the number of "package" stores as well as restaurants selling spirits in Estonia. Gross sales of alcoholic beverages had dropped by 12%.

On the other hand, according to E. A. Babayan, of the Soviet ministry of health, there has been a nation-wide increase not only in production of *samogon* — moonshine — but also in the output of what he called "locally made cheap alcoholic beverages that do not meet even the lowest standards".

He said: "These beverages which, in contrast to *samogon* are produced legally and sold in stores, lead more quickly to various psychotic phenomena than licensed vodka does. Although we have adopted important rules restricting the sale of alcoholic beverages, we have done nothing to control their production."

Babayan also disclosed information about the drinking habits of Soviet juveniles. He read out a letter from a teacher in Kiev who had been told by a number of her grade six girl pupils how they had gotten drunk on champagne at the birthday party of one of their classmates.

"Where were your parents?" the teacher asked.

"They were pouring the drinks," the girls replied.

The deputy-chief justice of the Soviet Supreme Court, S. G. Bannikov, reported on a recent poll according to which 75% of all eighth grade, 80% of all ninth and 95% of all grade 10 boys in the USSR use alcoholic beverages regularly.

(Compulsory education starting somewhat later in the USSR, eighth, ninth and 10th graders are 15, 16 and 17-year-old respectively).

A. F. Demyanenko, a justice of the USSR Supreme Court, reminded lower court judges that Soviet law allows courts to prohibit alcoholics from being paid their wages directly and that there are provisions for transmitting an alcoholic's pay to a court-appointed member of his or her family or to a legal guardian.

"This law," said Mr Demyanenko, "is not being used fully and all too often lower courts display a tolerant, compassionate attitude toward those who abuse alcohol.

"Good naturedness toward the drunkard is an impediment to combatting drunkenness," he said.

"Judges do not always take this into consideration when setting penalties," said the resolution.

According to the resolution the element of aggravation is obligatory and binding on all lower courts and may be circumvented by sentencing judges "only if they give written reasons for their decisions".

The resolution, which in the Soviet context has as much authority as a decree by the Communist Party Central Committee, also stressed the necessity of comprehensive and thorough investigation by local court and prosecution officials into cases involving the inducement of juveniles or the illicit manufacture of vodka and other homemade spirits.

Drugs re-emerge in Israel

By Macabee Dean

TEL AVIV — The drug problem, which seemed gradually to be dying down in the early 1970's, has emerged again with renewed vigor.

Strangely, it was Israel's latest two wars which brought about both upsurges.

The 1967 Six-Day War brought in its wake a considerable number of volunteers who inculcated in local youth the idea that smoking hashish was "modern and fashionable". When these volunteer young people, mainly American, went home, the hashish problem diminished.

The causes following the Yom Kippur War of October, 1973, were totally different. The considerable losses in manpower and sudden political isolation caused the country to go into a trauma. When this ended, in the months following the war, the population went into a state of bitter self-criticism and reform.

Faith in the country's leaders collapsed, and many of them, including Golda Meir, were ousted. A series of financial scandals rocked (and is rocking today) the country. The crime rate soared, especially crimes of violence, "protection", and extortion.

A certain moral rootlessness and disregard for the wisdom of the elders set in, and drugs again became popular — this time as a sort of "escape" from reality, rather than a way of showing-off.

According to a recent report by the Attorney-General, Professor Aharon Barak, the estimated number of people using drugs of all kinds in Israel is about 100,000. (Several years ago the estimated figure was 40,000).

Most of these, it is frankly admitted, are young people who uses hashish, more or less as an "experiment" in growing up. Most will not become addicts, but those who go on to try pep drugs and heroin may.

However, Professor Barak said there are at least 1,600 hard drug (mainly heroin) addicts in Israel, and the number is increasing at the rate of 150 a year. Some estimates, put the number of hard drug addicts as high as 3,000.

The authorities have tackled the hashish problem by educational methods and the Ministry of Health is planning to open "weaning" stations for hard drug addicts.

At present, the only possible way to wean the hard drug addict is to send him to one of 16 beds set aside in psychiatric wards.

The ministry has refused permission to several doctors to write prescriptions for drugs for addicts, to force the addicts to seek official government help. The only result so far has been that several pharmacies have been broken into and robbed of their drugs, and the black market price of heroin has soared.

Drunken tars put UK fleet in danger

By Harvey McConnell

LONDON — "What shall we do with a drunken sailor?" This question from the old sea shanty is today dramatically relevant to the crews of Britain's fishing fleets.

A large number of fishing boats put to sea these days with so many crewmen incapacitated by drink that the ability of the ship to survive any emergency in the first day or two after leaving port is seriously open to doubt, says the report of an expert committee to the government.

The study, by a committee set up by the Department of Trade and which included ship owners and crew union members, found a number of serious faults. These include:

- Heavy drinking ashore, leading to missed sailings;
- Refusal to sail, either by the drunken fisherman himself or by his colleagues;
- The prevalent and increasing practice of holding parties, known by crews as "cheer parties", aboard the vessel before and after sailing and with drinking going on sometimes for three days after sailing;
- The ease with which large amounts of liquor can be illegally placed aboard fishing vessels.

The experts admit in the report that they are unable to reach "firm conclusions about the reasons for the very heavy drinking which seems endemic to fishing industries, beyond the obvious explanation that despite the many improvements in working conditions, the fisherman's life at sea is still so harsh that some of them are psychologically incapable of facing the prospects of a new trip without first dulling the senses by overindulging in alcohol."

It adds: "Although we were told not more than about 15% of fishermen were immoderate drinkers, we were disturbed at the amount of evidence which showed the hardcore consisted of younger men between 18 and 35."

The supreme irony is that the experts agreed that "except for drink, we were unable to identify any single cause of poor discipline in the fishing industry". They also concluded there is "no single solution to the problem."

"We believe the true solution lies in a combination of effective statutory measures and industry-agreed arrangements associated with improved recruitment and training techniques."

The report recommends a tightening up of the law concerning a crewman's going aboard his ship while under the influence of alcohol or other drugs, as well as his taking alcohol aboard.

Tom Neilsen, secretary of the Federation of Trawler Skippers' Guild, said after the report: "Frankly, most indiscipline is caused by drink.

"We want skippers to have powers to discipline men, and rules to stop owners putting aboard illicit supplies of drink as an inducement to get men to sea."

More Letters...

(continued from page 8)

of too little guidance and affection in the home.

Too little attention has been focused on the physical damage to mind and body by alcohol. When one hears that 40% of all hospital beds in France are filled with alcoholics and that in the state-controlled Soviet Union, alcohol is becoming a major problem, we must take a closer look at what alcohol does to the body.

Alcohol acts as a diuretic increasing urinary losses of 35 out of 40 nutrients needed daily for bodily functions and good health as all but five of the vital nutrients (Vitamins A, D, E, K, and linoleic acid) are water soluble and readily lost in the urine. The excretion of magnesium, used by the body's nervous system and vital to muscle action and the brain, is increased **FIVEFOLD** by alcohol — inducing a deficiency in calcium that can cause nervousness, tension, stress, hostility and anger. The result may be violent behavior. Alcohol destroys many of the vital B complex vitamins with the result that damage to the nervous system can bring on violent anti-social behavior. Faulty nutrition can upset the normal mental process.

The more deficient our diets become, the greater the craving for alcohol and sugar. The largest organ in the body — the liver — can suffer permanent damage, with death the final result. The first step in removing the craving for alcohol is a well-balanced diet high in protein. "Sugarholics" often turn into alcoholics. The relationship between the craving for sugar and alcohol is close, often triggered by poor eating habits of highly-refined "junk foods" that supply only carbohydrates.

With $1 billion a year in Ontario going to repair the damages of malnutrition, isn't it time we look at the destruction it causes to the minds of our young people, with its resultant rebellious anti-social behavior? It's costing more than money!

Dean J. Kelly, Author
"Overfed and Undernourished"
Port Perry, Ontario

Hypocrisy

Sir:

It was recently reported that each adult in Ontario drinks an average of 300 bottles of beer, six bottles of wine, and 12 bottles of liquor every year.

However, I believe a majority of residents would favor raising the present drinking age of 18 back to 21.

Surely, these adults who consume that much alcohol are being hypocritical when they recommend such a policy.

It is so easy to demand leadership from politicians when we are not willing to demand leadership from ourselves.

William E. Rae
Scarborough, Ontario

The Journal welcomes Letters to the Editor

'Slavs boost consumption

MUNICH — Alcohol consumption has increased by 66% during the past decade in Yugoslavia.

According to *Nin*, the Belgrade weekly news magazine, per capita consumption of pure alcohol has jumped from 9 to 15 liters annually since 1966.

The magazine, which is semi-official, reports there are 700,000 alcoholics in Yugoslavia — about 3% of the total population of 21 million.

Early clues in alcohol score-board. . .

By Thomas Hill

BOCA RATON, Fla. — Diagnosing an alcohol problem after it has ruined a person's health, drastically depleted his resources, and perhaps left him down-and-out, is not good enough, says Dr Ronald J. Catanzaro of Florida.

Dr Catanzaro is director of the Palm Beach Institute, a private facility for the treatment of people with drug, alcohol, personality and interpersonal problems.

He revealed some of his own techniques for early identification of alcohol-dependence at the second annual Palm Beach County Alcoholism Education Seminar. It was held here at Florida Atlantic University under the joint sponsorship of 10 regional and state organizations concerned with alcoholism.

The Palm Beach psychiatrist, who is internationally known for his development of "familization therapy" (**The Journal**, July 1, 1972), has two lists of alcoholism symptoms which he has found helpful — an early stage and a late stage list.

He concedes that dividing this complex, multi-faceted disease into only two stages is an oversimplification.

"But it's an oversimplification that has some practical value," he told the seminar. "It's accurate enough for our purposes."

His list of early stage symptoms contains nine questions. The individual who gives affirmative answers to three or more of these questions has "an early alcohol problem".

Of the nine questions on early stage symptoms, Dr Catanzaro stressed one that he considers especially important: It is 'have I ever forced myself to go without drinking for a long period of time "to prove I really could take it or leave it alone"?

"I always say that I have one diagnostic question that will tell me whether someone has a drinking problem or not," Dr Catanzaro noted.

"When that person walks into my office I simply ask him one question. I say, 'Do you drink?' If the visitor uses one particular phrase I know he has a problem. That phrase is, 'I can take it or leave it alone'.

"What that person *thinks* he's saying is that he doesn't need it. But what he's *really* telling you is that he has just two choices — to take it or leave it alone. With only those two choices he can't be a so-called social drinker, although he may tell you that's what he is.

"Going without drinking for some time to prove he doesn't need it is real self-recognition that he has lost control. If I don't have loss of control over eating hot dogs I don't have to go without eating hot dogs for three months to prove something.

"What the man with the problem has proved to himself with his little experiment is that the only control he has is 100% abstinence."

Another question which Dr Catanzaro considers one of the keys to early diagnosis of an alcoholism problem is number one on his list: 'Do I frequently use alcohol as a drug to treat my nerves (or to help me relax, to put myself to sleep)?'

Discussion of this issue with the person who thinks he or she may have an alcohol problem, or with his or her spouse, will almost always give the therapist an insight into whether or not the individual really has a problem, Dr Catanzaro maintained.

Alcoholism has a long history, he said. Drawings in Egyptian tombs show it has been around for at least 6,000 years. But it's only in the last 40 years that a body of knowledge has been developed "to help people to help people".

"Within the last decade the field of alcoholism has changed radically. We began listening to what we'd been saying all these years. We'd been saying that only 5% - 10% of persons with alcohol problems cannot pay their own way. The other 90% or so are middle class individuals."

It's in this 90% — usually people with significant responsibilities at work, at home and /or in the community — that early diagnosis of an alcohol problem is important, so the disease can be treated before the individual's ability to handle his responsibilities is seriously impaired.

"This group is now finally getting the attention," Dr Catanzaro said, "hopefully without the other 5%-10% being forgotten."

. . . What is your alcohol I.Q.*? (Intake Quotient)*

EARLY-STAGE SYMPTOMS

		yes	no
1.	**Do I frequently use alcohol as a drug to treat my nerves (or to help me relax, to put myself to sleep.)?**	( )	( )
2.	**Do I frequently drink more than I intend?**	( )	( )
3.	**Am I drinking more in recent years?**	( )	( )
4.	**Do I spend more money for drinking than I should at times?**	( )	( )
5.	**Has anyone close to me become concerned about my drinking, particularly my spouse?**	( )	( )
6.	**Do I tend to minimize my drinking?**	( )	( )
7.	**Am I harder to get along with since I began drinking more?**	( )	( )
8.	**Have I ever forced myself to go without drinking for a long period of time "to prove I really could take it or leave it alone"?**	( )	( )
9.	**Have I ever had a blackout or loss of memory while drinking?**	( )	( )

LATE-STAGE SYMPTOMS

1.	**Do I lose time from work due to drinking?**	( )	( )
2.	**Is drinking endangering my health?**	( )	( )
3.	**Do I require a drink the next morning?**	( )	( )
4.	**Have I ever had the "shakes" after a drinking spell?**	( )	( )
5.	**Have I ever been on a "bender" (had D.T.s, etc.)?**	( )	( )
6.	**Have I ever quit a job or been fired because of drinking?**	( )	( )
7.	**Has my spouse ever threatened to divorce me because of my drinking?**	( )	( )

WHAT'S YOUR ALCOHOL I.Q. SCORE?

EARLY-STAGE I.Q. If your I.Q. is three or more (one point for each positive answer), then you have an early alcohol problem.

LATE-STAGE I.Q. If your I.Q. is two or more (one point for each positive answer) you have an advanced alcohol problem.

**Dr. Catanzaro's breakdown of pointers to early-stage and late-stage alcohol problems.*

New Books

by RON HALL

Living Sober

. . .by Alcoholics Anonymous World Services,
(459 Grand Central Station, New York, NY 10017), 1975.
95p. $1.50

Although it does not offer a plan for recovery from alcoholism, this booklet presents a collection of some of the techniques that AA members have perfected for avoiding drink.

Breathalyzor??? Or Breathaliar???

. . .by Arne B. Hansen
Arne B. Hansen,

(PO Box 10638, Glendale, CA 91209), 1975.
42p. $1.00

The author feels that too many drivers are not aware of the procedures and laws governing the utilization of the breathalyzor, and he stresses the danger involved when a motorist is subjected to a breath test after the use of an alcohol based mouthwash.

Aminergic Hypotheses Of Behavior: Reality Or Cliche?

. . .edited by Bruce Kenneth Bernard
National Institute on Drug Abuse,
(11400 Rockville Pike, Rockville, Maryland 20852), 1975.
155p. $6.25

Views on the relationship between the function of the brain monoamines and their effect on behavior are presented in the 10 papers which comprise this monograph. Progressing along a continuum of behaviors from those which are well-defined as causally related to the brain amines to others which have a speculative relationship, the papers deal with parkinsonism, sleep, agression, and the relationship between monoaminergic systems and the behavioral effects of drugs.

Other Books

Drug Interactions. The Effects of Alcohol and Meprobamate Applied Singly and Jointly in Human Subjects — Carpent, J.A. (editor. Journal of Studies on Alcohol, Supplement No. 7, November, 1975. 193p.

Biochemical Pharmacology of Ethanol — Majchrowicz, Edward (editor). Plenum Press, New York, 1975. Proceedings of the American Chemical Society Symposium held in Chicago, August, 1973. 367p.

An Assessment of the Diffusion of Heroin Abuse to Medium-Sized American Cities — Greene, M. H., Kozel, N. J., Hunt, L. G., and Appletree, R. L. Special Action Office for Drug Abuse Prevention, Washington; 1974. 106p.

Drug Abuse and Drug Policy — Bejerot, Nils. Acta Psychiatrica Scandinavica Supplementum 256, 1975. "An epidemological and methodological study of drug abuse of intravenous type in the Stockholm police arrest population 1965-1970 in relation to change in drug policy." 277 p.

The Vietnam Drug User Returns — Robins, Lee N. US Government Printing Office, Washington, 1975. 95 p.

Involving the Physician Through Alcohol Education and Training — Eastern Area Alcohol Education and Training Program Inc., Bloomfield, 1975. 81p.

DIA/FDA/NLM Symposium on Unusual and Under-Utilized Drug Information Resources — Drug Information Journal, conference held October, 1974.

30th International Congress on Alcoholism and Drug Dependence — Tongue, Archer and Tongue, Eva (editors). International Council on Alcohol and Addiction, Lausanne, 1975, 99p.

Experimentation in Controlled Environment: Its implications for Economic Behavior and Social Policy Making — Miles, C. G. (editor) Addiction Research Foundation, Toronto, 1975. Papers presented at the International Symposia on Alcohol and Drug Research. 170p.

5th International Institute on the Prevention and Treatment of Drug Dependence — International Council on Alcohol and Addictions, Lausanne, 1975. 156p.

QUAD Review 4 — Drug quality assessment program. Information Canada, Ottawa 1975. 215p.

Coming Events

In order to provide our readers with adequate notice of forthcoming meetings, please send announcements as early as possible to: The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

American Orthopsychiatric Association 53rd annual meeting — March 3-6, 1976, Atlanta, Georgia. Information: AOA office, 1775 Broadway, New York, New York, 10019.

Conference on Interactions of Drugs of Abuse — March 9-12, 1976, New York, New York. Information. Ms E. Marks, New York Academy of Sciences.

American Society for Clinical Pharmacology and Therapeutics — March 18-19, 1976, Seattle, Washington. Information: Mrs. Elaine Galasso, ASCPT.

Texas State Conference on Issues in Alcoholism — March 21-23, 1976, Arlington, Texas. Information: Alcoholism Council of Texas, 510 South Congress, Suite 406, Austin, Texas, 78704.

Third National Drug Abuse Conference — March 25-29, 1976, New York, New York. Information: Joyce H. Lowinson, MD, Chairperson, National Drug Abuse Conference, 1500 Waters Place, Bronx, New York, 10461.

Pediatric Pharmacology — April 1, 1976, Toronto. For information: Dr Robert Imrie, Etobicoke General Hospital, Rexdale, Ontario.

International Conference on Alcoholism and Drug Dependence — April 4-9, 1976, Liverpool, England. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

National Alcoholism Forum — April 9-13, 1976, Washington, DC. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Work in Progress in Alcoholism 1976 — May 6-8, 1976, Washington, DC. Information: National Council on Alcoholism, 2 Park Ave., New York, New York, 10016.

22nd International Institute on the Prevention and Treatment of Alcoholism — June 7-12, 1976, Vigo, Spain. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

The Committee on Problems of Drug Dependence — June 7-9, 1976, Richmond, Virginia. Information: Committee on Problems of Drug Dependence, NAS-NRC, 2102 Constitution Ave., NW, Washington, DC, 20418.

Utah School on Alcoholism and Other Drug Dependencies — June 13-18, 1976, Salt Lake City, Utah. Information: University of Utah School on Alcoholism and Other Drug Dependencies, PO Box 2604, Salt Lake City, Utah, 84110.

Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies — INFORMACTION 1976 — June 20-25, 1976, Toronto, Ont. Information: W. J. Gilliland, Conference Manager, Addiction Research Foundation, 33 Russell St., Toronto, Ont., M5S 2S1.

Sixth International Institute on the Prevention and Treatment of Drug Dependencies — June 28-July 2, 1976, Hamburg, Germany. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

The Third Institute on Drugs, Crime and Justice in England — July 6-28, 1976, Christ's College, Cambridge University. Information: Dr Arnold S. Trebach, Director, Institute on Drugs, Crime and Justice in England, Centre for the Administration of Justice, The American University, Washington, DC, 20016.

Eleventh International Conference on Medical and Biological Engineering — Aug. 2-6, 1976, Ottawa, Ontario. Information: Conference Office, National Research Council, Ottawa, Ontario, K1A 0R6.

Ninth International Conference on Health Education — Aug. 29-Sept. 3, 1976, Ottawa, Ontario. Information: Canada's Organizing Committee, Ninth International Conference on Health Education, c/o Canadian Health Education Specialists Society, PO Box 2305, Station D, Ottawa, Ont.

27th Annual Meeting of Alcohol and Drug Problems Association of North America — Sept. 12-16, 1976, New Orleans, Louisiana. Information: ADPA, 1101 Fifteenth St. NW, Washington, DC, 20005.

First World Conference on Therapeutic Communities — Sept. 20-25, 1976, Katrineholm, Sweden. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Dealcoholized drinks

Are we going to swallow them ?

ALTERNATIVE DRINKS for alcohol abstainers have been readily available in Europe for many years. But the gradual introduction of dealcoholized beverages to the sophisticated North American market has met with some obstacles.

For the moment, Ontario is being used as the primary test market in North America for dealcoholized wines. The fate of such wines, in terms of the rest of Canada and the United States, may well rest with Ontario's consumers and its Liquor Control Board.

THE BACK PAGE

By Karin Sobota

THE EMERGENCE of non-alcoholic alternative drinks in Europe has been called Teetotal Lib by abstainers weary of substituting sweet soda pop for more pleasant tasting, but alcoholic, drinks.

The advantages of dealcoholized beverages to a wide segment of society may, therefore, be captured in a few brief scenarios:

- Non-drinking couples are finally able to enjoy the dry, flavorful taste of wine at a party without having the mood-changing effects of the alcohol they are trying to avoid. After as many drinks as they please, they are able to drive home safely.
- Teenagers under the legal drinking age can indulge in the "grown-up" taste of dealcoholized beer — without side-effects — and with parental approval.
- And finally, a person on a self-imposed diet can enjoy a glass of dealcoholized wine without guilt as it contains about half the calories of "regular" wine.

The advantages of dealcholized products to teetotallers, situational abstainers, and alcoholics, are numerous. The trouble is, those who want to purchase these drinks may not be able to find a store that sells them.

In Ontario and Hull, Quebec, dealcoholized wines are being market-tested in delicatessens by Carl Jung Wines Canada Limited, the sole distributors of non-alcoholic wines in North America. Sales are not high and the company is blaming the situation on the obstinacy of the Liquor Control Board (LCB) in Ontario.

Public acceptance of any dealcoholized product depends upon the successful marketing of the Carl Jung "test case", say its producers. The dealcoholized wines the company produces have to be sold through LCB retail outlets to be both accessible to and accepted by the public, the Carl Jung Company maintains.

Unfortunately, the Board, which decides what to sell through its outlets, as well as what not to sell, does not seem eager to list Carl Jung dealcoholized wines.

Why not?

Only the Board knows for sure and it's adamant in its refusal to discuss the matter.

Even the Carl Jung people are not sure why their product is not being accepted by the Board.

"After all," says Barbara Cowan whose title is health director and public relations appointee for the company, "the Liquor Control Board of Ontario should be concerned with the 'control' part of its name and selling a good-tasting alternative beverage in their stores would be the first positive step."

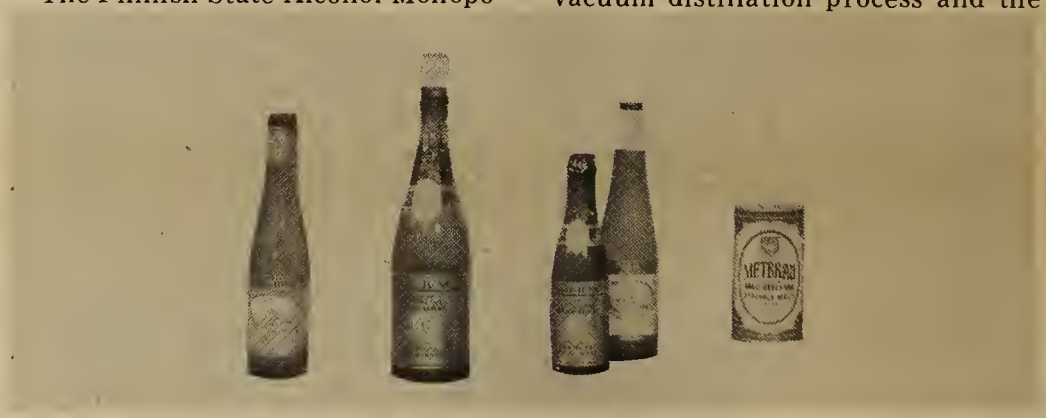
In a written brief to General George Kitching, chief commissioner of the LCBO, and with whom the decision ultimately rests, Mrs Cowan writes:

"The concept of providing an alternative beverage to alcohol is accepted by the Addiction Research Foundation of Ontario as a small answer to the problem of alcoholism."

The product of the Carl Jung company, she tells everyone, is an answer to all people, for whatever reason, who do not want to drink alcohol — an estimated 20% of Ontario's population over the age of 15.

Mrs Cowan backs up her statements about the potential widespread acceptance of dealcoholized beverages in North America, by quoting statistics from Europe where sales of such products by government-controlled liquor outlets and private food stores are increasing each year.

The Finnish State Alcohol Monopoly, known as ALKO, carries three dealcoholized products. In 1969, more than 12,000 cases were sold and, by 1973, the figure climbed to more than 17,000.



Sweden, which carries 12 varieties of non-alcoholic wines, sold 48,250 cases in 1970. That figure rose to 92,092 cases in 1974, and since then, sales have increased 20% per year.

"As proven by the Scandinavian countries' experience, the sales of dealcoholized wines have increased by 100% since 1970 when they became available in government liquor stores," Mrs Cowan states. Simply put, she says, dealcoholized wines won't succeed without government liquor store exposure.

Why not?

Because, she explains, people are not prepared to spend an extra $3 of grocery money to purchase wine.

Dealcoholized wines should be as available to the public as are retail liquor outlets, she says. And, the LCBO should be concerned with providing a sophisticated alternative to alcohol.

Recently-amended legislation does allow LCBO outlets to stock non-alcoholic beverages in addition to their regular supplies, but dealcoholized wines will not necessarily appear on the shelves.

To prepare itself to meet the criteria for possible listing, the Carl Jung company is prepared to produce a drier wine. It now bottles a semi-dry white, a semi-sweet red, and a white sparkling product for Canadian consumption.

Originally, the dealcoholized wines produced by the Carl Jung vineyard in Rudesheim, West Germany, were bottled under the "Counterweight" label as a diet wine. Its failure to sell on grocery shelves was blamed on non-existent promotion, a mistake that won't happen again, according to Mrs Cowan.

While it's difficult to obtain the approval of the LCBO, it may prove even more difficult to gain public acceptance of this alternative.

Like decaffeinated coffee, dealcoholized wines lose some flavor through the process which eliminates all but ½ of 1% of the alcohol. (In Europe dealcoholized wines contain as much as 2½% alcohol).

The wine produced by the Carl Jung company is derived from the company's major industry — the production of brandy.

The brandy is made by distilling wine to produce a higher alcohol concentration. The company uses a vacuum distillation process and the residue becomes the dealcoholized wine.

And that's the only way of making the dealcoholized wine industry a profitable venture, Mrs Cowan admits.

According to Dr Joan Marshman, head of Pharmacological Sciences at the ARF, it's technically impossible to become intoxicated by drinking wine containing so little alcohol.

She estimates it would be necessary to consume 25 times the amount of the dealcoholized product as regular wine containing 12% alcohol by volume, to have the same effect.

While dealcoholized beverages may not produce a pharmacological reaction, a psychological response may occur to those who drink them while on Antabuse treatment.

"It is not outside the realm of possibility that these people may experience a pseudo-reaction, Dr Marshman says.

Nevertheless, the product has the growing support of a number of people in the alcoholism field, including Dr Wolf Schmidt, ARF Associate Research Director.

He believes non-alcoholic wines to be a pleasant-tasting substitute for alcohol and one that can be used by both alcoholics and young children and as an accompaniment to meals.

The Carl Jung company's optimism about seeing their product marketed through retail liquor outlets rests with the new membership of the LCB, who will take their seats in the near future.

If the new board in Ontario doesn't accept the concept of non-alcoholic beverages in its stores, the province of Newfoundland will be approached, as government officials there have indicated an interest in selling dealcoholized wines through their liquor stores.

While the "battle" continues, a reverse marketing procedure is being established for the potential sale of dealcoholized beer.

Again, Carl Jung wines has initiated steps to produce such a beer for the Ontario market and is now negotiating with an Ontario brewery to buy fermented beer and remove the alcohol from it. From there the beer would be bottled and sold to the public and/or to restaurants as draft beer.

Cardinal Moussy a dealcoholized Swiss beer product now sells for about 60c a can in Ontario. The Carl Jung company hopes to undersell *Moussy* by about half, and plans to do so by regaining excise taxes paid to the federal government through the original purchase of beer from the brewery before the dealcoholization process takes place.

Metbrau, an American-produced malt beverage has been sold in Canada for three years. Although the Metropolis Brewery which produces this beverage is not saying by how much, they do indicate its sales are increasing.

Metbrau, however, and *Birrell*, a Swiss malt beverage, never had any alcoholic content to begin with; do not go through the traditional beer brewing process and, as a result, cannot be classified as a beer. Several other American-produced malt beverages fall into this category, but there are only a few brands.

As sketchy as the variety of dealcoholized beverages is information about non-alcoholic drinks. Both the US National Clearinghouse on Alcohol Information, and the ARF's Resource Library have little on file.

And since the subject is relatively new here, public reaction remains to be seen.

Will other wineries enter the scene and create a competitive market?

Chateau Cartier, an Ontario winery, has developed a "wait-and-see" philosophy, depending upon the success of the Carl Jung experiment. Other wineries will likely follow the same pattern.

But, for the future and probably for this continent, price, taste, and above all public acceptance of the dealcoholized products in Ontario, Hull Quebec and even Newfoundland, will decide the fate of this alternative for North America.

Barbara Cowan

"Dealcoholized wines won't succeed without government liquor store exposure."

George Kitching

The General won't explain why he doesn't want to see non-alcoholic beverages in liquor stores.

Wolfgang Schmidt

"Dealcoholized wines are a pleasant-tasting substitute for alcohol."

Joan Marshman

"It's technically impossible to become intoxicated by drinking dealcoholized wine."

New data expose high heroin use

By Milan Korcok

WASHINGTON—The problem of heroin use in the United States is getting worse and it was wrong to be so optimistic about an apparent reduction of use in 1973: This encouraged claims that the war on drugs had "turned the corner".

Announcing a new series of reports on heroin use indicators, Dr Robert DuPont, director of the National Institute on Drug Abuse (NIDA), admitted he had been wrong both in suggesting the drug epidemic which flared in the 60s had receded in 1973, and in generalizing for the nation as a whole, drug use data derived primarily from New York City and Washington, DC.

"What was at that time described by me as well as others as a secure national trend (of reduced heroin use) turned out to be regional and temporary," said Dr DuPont.

"We know from a number of sources that 1973 was a low point in terms of the last five or six years in the heroin problem. But we now have clear evidence that since 1973 the heroin use problem in the United States has deteriorated."

Though the country may not be experieneing the same high peaks of usage that characterized the epidemie in the 60s, there is a steady, progressive increase, a "very worrisome kind of trend".

The report released by Dr DuPont was the first in a series that will monitor use trends over time. The measurement model being used relies on medical examiner re-

(See — Heroin — Page 12)

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Agency tightens its grip in BC

By Tim Padmore

VANCOUVER – British Columbia's streamlined Alcohol and Drug Commission is expected to adopt a hard line approach to the chronic drug abuser.

The commission's new chairman, Bert Hoskin, former head of the Narcotics Addiction Foundation (now called the Narcotics Addiction Service), is well known for his outspoken criticism of the "permissive" approach of the commission.

He has already given notice he intends to tighten the reins, both on the agencies the commission supports and on the drug abusers themselves.

In his first public appearance since his appointment by the new Social Credit government, he said the commission will de-emphasize methadone maintenance programs for heroin addicts and work on plans for compulsory treatment of addicts who come before the courts and of alcoholics in detoxification units.

(See—You—Page 7)

The ambience of the English-style pub is being recreated in British Columbia where neighborhood pubs are fast gaining popularity. See Page 3 for the story.

GM plan reveals alcoholic workers

By Karin Sobota

OSHAWA—One of the largest companies in Canada reckons it has identified 30% of its employees who have a problem with alcohol since the introduction in 1972 of an alcoholism recovery program.

General Motors of Canada bases its figure on estimates by the Addiction Research Foundation of Ontario that 7% of employees in industry have an alcohol problem.

Statisties just released to **The Journal** by the company show that to date 640 of GM's 34,000 employees across the country have been found to be problem drinkers. Aecording to the ARF theory, GM may have as many as 2,400 problem drinkers.

Other statistics released by GM indicate costs to the eompany resulting from sickness and aecidents benefits, workmen's compensation claims, and grievance procedures filed by employees, have decreased considerably from employees who have had treatment for their alcoholism.

Ray Lunn, co-ordinator of GM's Alcohol Reeovery Program, outlined the statistieal study whieh began in 1972.

"At the Oshawa plant, (where approximately 15,000 people are employed), we did a study on 152 hourly rate employees who had been referred to our medical department. Of 152, 104 went for treatment (for alcoholism), while 48 refused."

Study results were well received:

• One year before treatment, 182 sickness and aeei-

(See — GM — Page 12)

More ammo for the anti-smokers

By David Milne

ALBUQUERQUE—An enzyme defect associated with the development of emphysema may give anti-smoking campaigners much-needed ammunition, Dr Kenneth M. Moser said during an interview at a meeting here of the American College of Physicians.

Since finding that people deficient in the proteinase inhibitor alpha-1-antitrypsin (A-I-A.T.) are destined to develop chronic obstruetive lung disease, investigators have correlated carrier phenotypes with pulmonary function, structure, and clinical behavior, said Dr Moser.

Dr Moser is director, pulmonary division, University Hospital of the University of California, San Diego.

It is now known that more than 90% of the population have normal levels of A-I-A.T. or MM phenotype.

About 5% are MZ phenotype and have intermediate levels of A-I-A.T., although the level fluctuates.

And one out of every 1,000 people is homozygous ZZ and has extraordinarily low levels of the inhibitor.

The ehances of people with ZZ phenotype developing emphysema are elose to 100%, and they begin to get symptoms when they are 28 instead of 48 years old, depending on how much they smoke.

"I think this is a thoroughly compelling reason for getting people not to start smoking and for smokers to stop," he said.

"One of the problems in persuading people not to smoke is that we cannot say it is definitely going to harm them.

"Now we can say that they are going to get emphysema

(See — Emphysema — Page 2)

• *"The reason whey teenage drug prevention programs haven't worked is that they reached the kids too late," according to Kerry Stowell, the inventor of an unusual health-oriented teaching program aimed at children. See Page 4 for story.*

• *"Le Patriarche," a self-styled megalomaniac, poses with his family outside their chateau-therapeutic community, La Boère. Life here is a constant psychotherapy session. See The Back Page.*

More Inside

Drug abuse in the elderly — there are more questions than answers.

Drug use by aged will increase and needs more study now...

By Jean McCann

BOSTON—The elderly of the future may be much more likely to abuse drugs than old people of today, according to Dr Richard V. Phillipson of the National Institute on Drug Abuse.

At the annual meeting of the American Association for the Advancement of Science, Dr Phillipson predicted: "With the present younger generation more prone to self-medication, and using greater amounts of psychoactive drugs, it is more than probable that as this group ages there will be an increase in the problem of misuse of drugs by the elderly."

He also predicted that in future, as many as one of every three elderly people will be using psychoactive drugs, with their abuse potential.

What is of particular concern in all this, he said, is that at present there are too few studies and too few recommendations about how drugs should be used by the elderly.

Studies that do exist show drugs are metabolized differently in older than younger people. Clearance of a drug may be greatly delayed in the older group.

This fact is being greatly neglected in the elderly as are questions relating to alcohol and caffeine consumption, cigarette smoking, and the concomitant taking of other medications, said Dr Phillipson.

He said it is not uncommon, for instance, for a patient to enter a nursing home for long term care and to "have three or more new drugs prescribed, with no effort made to review the drugs already ordered by the physician outside.

"It is not unknown for patients to receive four or five drugs regularly, with twice as many more ordered to be administered 'when required'."

Psychological factors as well as physical factors must also be studied further, Dr Phillipson said. When is the patient with mental symptoms suffering from organic brain syndrome, a functional disorder, or cerebral arteriosclerosis? How do psychoactive drugs act in the aged?

This last question is especially important, he said, as the drugs most frequently used in the aged include thorazine, chlorpromazine, diazepam, chlordiazepoxide and amitryptaline. These are in addition to "the three most common 'recreational' drugs—caffeine, nicotine, and beverage alcohol".

Dr Phillipson believes physicians prescribing drugs, especially to elderly nursing home patients, should be required to certify that they have reviewed the drug histories, and eliminated all unnecessary medications, before prescribing new ones.

He was also critical of the Food and Drug Administration for not taking into account the needs of the elderly when approving new drugs for use.

"FDA regulations do not make it obligatory that aging be considered a factor when new drugs are tested for psychoactivity or for abuse potential", he said.

"Surely there is a case to be made to require that all studies of drug metabolism, pharmacokinetics and efficacy include a reasonable sample of elderly as well as younger subjects."

...Sleeping pills are unnecessary in the elderly

By Harvey McConnell

EDINBURGH — Sleeping pills for the elderly are not necessary because the majority will suffer naturally from broken sleep, believes Dr Ian Oswald, of the department of psychiatry at the University of Edinburgh.

Dr Oswald is a committee member of CURB (Campaign on the Use and Restriction of Barbiturates) organized by physicians to advise colleagues on the prescribing of barbiturates. The group is government financed, as it is deemed to be in the public interest, but is completely free and independent.

Dr Oswald told a conference organized by CURB that studies have shown that with advancing age, sleep is more broken in the majority of men and women. At the same time, surveys find it is the older people who take the majority of sleeping pills.

"But as broken sleep is a normal phenomenon it should rarely be necessary to prescribe any sleeping pills, barbiturate or otherwise," he said.

Benzodiazepines are said to promote normal sleep "but electrical brainwaves show that this is untrue".

Research has found that the withdrawal of both barbiturates and benzodiazepines can induce anxiety by rebound "although both are prescribed to relieve anxiety".

Both of the drugs can interfere with skills needed the following day. They can also impair judgment to the extent that an overdose can occur.

Dr Oswald said that phenothiazines do not have the disadvantage of dependence or abuse but tend to leave the patient dull the next day.

He added: "It is important that a full history is taken by the doctor from depressed patients. If the depression is a reaction to social or emotional situations, anti-depressants will not help and may be taken in overdose."

Dr B.R. Ballinger, consultant psychiatrist with the Royal Dundee Hospitals, said from the psychiatric point of view barbiturates are not as serious a problem as alcohol. However, their prescription does present many difficulties.

He told the conference: "Although withdrawal of the drug is often successful, the results of long-term followup have not always been very encouraging."

Mild dependence on psychotropic drugs "is found in up to one quarter of psychiatric hospitals admissions if a broad definition of dependence is made, and barbiturates and methaqualone are particularly liable to cause this".

Another problem with psychiatric patients is they do not take drugs as they are prescribed. "It has been found that 47% were not taking the drugs as prescribed, according to the results of urine tests," Dr Ballinger added.

Emphysema warning for some smokers

(Continued from page 1)

much earlier if they are in the high risk group.

"It is very clear that persons who are ZZ homozygous for the enzyme defect have a compelling reason not to smoke.

"In their case the risk is 100%.

"Now if MZ carriers have an increased incidence of lung disease—and this is currently under debate—it would mean that 5% of the population are at increased risk by smoking."

The large number of people at risk would give a strong thrust to anti-smoking campaigns, he said.

Pot may not wash in Gotham City

By Wayne Howell

OREGON, ALASKA, California... the states are dropping like dominoes, Laos! causes in the struggle against the decriminalization of marijuana.

It has been predicted at least one-half of the remaining states will make equivalent legislative changes within the next few years. America, it appears, is finally going to get 'greened'. But is it?

America certainly has not quite greened the way Charles Reich expected it would when he wrote *The Greening of America* in 1970, the book that gave the vague philosophical musings of the flower children a patina of intellectual respectability and gave cannabis credit for helping to liberate young minds from the drudgery of Consciousness I and Consciousness II into the enlightened state of mind known as Consciousness III.

For America has not got greener since 1970, it has got greyer. It appears the heady hopes of the late 1960s — freedom, love, and flower power, a chicken in every pot and a little pot in every chick—have been dashed by the economic realities of the 1970s.

Not surprisingly, college protests and radical politics are Out. Hitting the books is In, interrupted on occasion by a good old-fashioned beer bust at the frat house.

These social changes have been documented by sociologists (there is never a shortage of sociologists—pop and not-so-pop when it comes to studying 'the mood of the campus') and are also confirmed by more reliable sources, the comic strip *Doonsbury* for instance.

So it appears that if the sociologists have indeed described the tides in the affairs of young men correctly, then we are in for a flood of 1950s-style High Seriousness. For it was a fine thing to make a protest against the rat-race by dropping oul and turning on—as long as you knew that they were holding a place for you on the treadmill. But now . . . well everyone agrees, it would be nice to get into medical school. Those archetypal Jewish mothers were right all along.

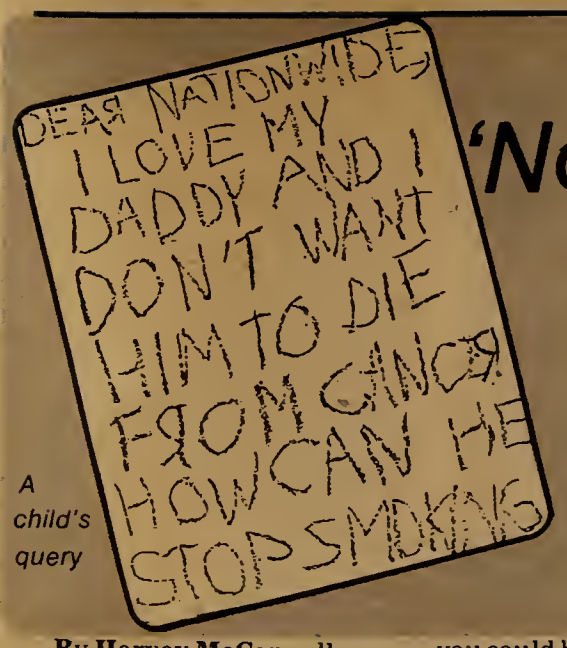
Pharmacological implications? It may turn out that pot is a pastoral pleasure and pastime, unsuited for the era of the 1970s. Prior to the 1960s when the post industrial age was declared, somewhat prematurely as it turned out, by Reich and others—marijuana had never made significant inroads into modern industrial western cultures. It was a third world weed.

In Vietnam, before the Americans arrived, cannabis was a drug used by old men who couldn't afford steady visits to the local opium emporium; young men who went to Saigon to 'get ahead' (Consciousness II types) would have nothing to do with it. And although they grow good grass in Bolivia, it is not by accident that those who have the fortune (or the misfortune) to be caught up in the industrial state—the tin miners—prefer to chew coca leaves.

Marijuana, in short, may be a kind of Katmandu cocktail, a sort of Marrakech martini, that just doesn't mix with competitive capitalism and Gotham go-getting.

All this is not to suggest that pot will become a pariah among mind-bending drugs; there will always be those who for various reasons take it as their own. It is to suggest that the decriminalization of marijuana will perhaps not have the dire consequences predicted by those who fear its legalization or quasi-legalization will lead to fundamental social changes. For there have been, and there are occurring now, fundamental social changes as a result of economic circumstances and it may be that these changes are inimical to the widespread use of marijuana.

Perhaps it is not coincidence then, that students have turned to alcohol with a vengeance; Ripple's the thing and Boone Farm's the fling. There's one thing about booze, the next morning when you get up if you get up—you're ready to stomp all over the first guy that dares get in your way. This is not a bad attitude to have if you want to get into graduate school.



A child's query

'Now the BBC evening news but first here's a word against smoking'

Michael Barratt

By Harvey McConnell

LONDON — A concerted effort to give up cigarettes by team members before and behind camera on the British Broadcasting Corporation's nightly news and feature television program, Nationwide, has turned, literally, into a nationwide anti-smoking campaign.

Viewer reaction to the Give-Up-Smoking-With- Nationwide idea has surprised the producers: More than 1,000 people have troubled to write in to say they have given up smoking along with members of the program team.

Thousands more have sent letters and cards of encouragement for anchorman Michael Barratt and his fellow newspeople up and down the country. Many have sent snippets of advice on how to suffer through the pangs of giving up.

The campaign, which started on New Year's Day, has also had a profound impact on many young people, who are obviously worried about a parent who smokes.

Two examples of the many cards from children: "Dear Nationwide: My mother will not stop smoking and I wonder if you could help me." And: "Dear Nationwide. I love my daddy and I don't want him to die from cancer. How can he stop smoking?"

The campaign has made a big impression on Dr David Owen, Minister of State for Health and Social Security. He told Mr Barratt during a recent question and answer session with viewers: "I think it is one of the best things that has happened.

"What you are doing is to identify yourselves with the problem. In your very real way you are adopting an addiction clinic approach. I think it is very successful because it *is* going out nationwide."

Mr Barratt, a smoker for years, said the campaign owes its origin to the decision by Jane Smith, a production assistant, to stop smoking just before Christmas. Several other production people joined her.

When the team started to think about the New Year and resolutions, the idea of a national campaign involving the broadcasters themselves was born.

Mr Barratt said he felt he knew what would *not* work. Past scare campaigns about dangers from lung cancer "have shocked people but tended to make them switch off."

He knew from his own experience doing four commercials for television and movie houses — "and I was accused of hypocrisy at the time because I smoked" — along lines of "look how much money you save" did not work either.

"It has got to be a team effort, and that is what it is for ourselves on the program. We hope that the viewers will join in with us," he explained.

Weekly practical advice is given by Dr Charles Fletcher, a consultant physician and chest specialist who is also a founder member of ASH (Action on Smoking and Health).

Reporter Bob Wellings, another heavy smoker, said: "It is a very supportive thing and everyone is suffering. We arrive at the studio in the morning and the talk is 'how did you get on last night' and 'how are you feeling.' All of this gives a sense of help."

Regional reporters have joined in the campaign and give weekly accounts on how they are faring. Nobody pretends it is easy and ways of discouragement have ranged from eating ridiculously hot curries to sucking vile-tasting throat lozenges.

Mr Wellings said even on days off, team members are in contact. Mr Barratt, who spent a recent week in Belfast, Northern Ireland, was on the phone every morning offering solace and words of advice.

The only person in the program team who stopped and then starting smoking again is Valerie Singleton. She did admit, however, she was not 100% dedicated to the idea of giving up when the plan started.

In his appearance on the program, Dr Owen told questioners the idea of a massive drop in tax revenue if everyone were to stop smoking is often voiced, but in reality is a red herring.

"Nobody expects it even if they want to — and nobody wants people to give up smoking more than I. But I know perfectly well they are not going to suddenly stop.

"The best we can hope for is a slow process in which people give up smoking."

In this way new ways could be found gradually of replacing the billions of dollars collected annually in tobacco tax.

Dr Owen added: "I think it is hard to give up smoking and I think we have to be understanding of the difficulties. The biggest problem is to decide what is the role of government.

"We live in a free society. To what extent does the government tell you you will do the following?

"I have done my best to persuade and to educate and to do the very best I can with disincentives to people to give up smoking, especially the young. But there is a limit to what government can do."

Dr Owen said a differential tax between cigarettes and pipe tobacco — at present the tax is put on the leaf as it enters the country — "is worth looking at as a serious proposition".

"However, there is always the problem that many cigarette smokers who switch to pipe tobacco still inhale and this would be even worse for them than cigarettes."

Dr Owen said: "We also need to know a great deal more about the scientific component of smoke and what it is that makes people, I would say, addicted."

Vancouver's answer to ye olde Englishe pub

By Tim Padmore

"And it's no, nay, never;
"No, nay, never, no more,
"Will I play the wild rover,
"No never, no more!"

VANCOUVER — Shoulder to shoulder, glasses held high, a hundred happy voices resonate in the simulated oak rafters of British Columbia's first genuine neighborhood pub.

It's Friday night, standing room only, and the only clear space is in the no man's land between the dart boards and the dart players.

Outside the Dover Arms, a queue that started forming at 7:30 pm stretches around the corner; inside, beer and wine, Cornish pasties, and meat pies are served by waitresses or from the bar; piano player John Ainsworth leads the sing-along; and between ditties, conversation burbles and fellowship ripens.

For decades, BC beer drinkers have had to do their quaffing in vast, unsavory hotel beer parlors. These are places where an almost palpable atmosphere of smoke and stale beer screens prostitutes and drug addicts trying to score, where studiously bored businessmen watch a genuinely bored stripper, where pounding rock music swallows up the possibility of conversation.

No, nay, never, no more.

Two years ago, as part of a legislative package liberalizing BC liquor laws, the former NDP government okayed the neighborhood pub.

"We hope the new pubs will introduce a kind of facility with style and class and elegance, that will be smaller and promote moderation and companionship," said then attorney-general Alex Macdonald.

A year ago, the Dover Arms opened in the midst of the apartment towers of Vancouver's West End. It was modelled as a sort of Hollywood image of a British pub, and it has been bursting at the seams ever since.

Says ex-Briton Barry Stephenson, a salesman for a local steamship company who drops in at the Dover Arms nearly every evening:

"It's one of the closest things I've come upon to an English pub. It's nothing to do with the decor; it's principally the clientele—it's one of the easiest places where you can talk to someone without the suggestion you're trying to pick them up."

But despite their obvious popularity, neighborhood pubs have been slow in coming. The liquor administration branch lists just seven pubs on the Lower Mainland, and 38 throughout BC.

One problem for prospective pub owners is that local municipalities must still approve the opening of any pub, as must residents living in its vicinity. And, understandably, many municipalities have been opposed.

Although the pub size is limited to 75 seated and 25 standees, and closing is 11:30 pm (last round at 11:00), a neighborhood pub can have a distinct neighborhood impact.

One West Ender, a non-drinker whose apartment overlooks the Dover Arms, describes the nightly scene:

"It's perfectly quiet until 11:30, and then all those drunks spill out onto the street singing their beery songs."

He concedes he made only a small modification in his bedtime to accommodate the disturbance, but pointed out there may be early risers for whom the noisy nightly exodus would be a more serious problem.

The Rose and Crown pub in the Vancouver bedroom suburb of Tsawwassen is one of these. Less determinedly old country than the Dover Arms, it nevertheless features a pair of well-used dart boards. Drapes unsuccessfully disguise the pub's storefront origin, and the organ player, whose instrument is alongside the dart range, sometimes has to retreat when the Canadian-trained dart throwers get a little wild.

But the small crowd on a recent week night was cheerful, if not roistering, the help, friendly, and the Guinness was available at room temperature or chilled.

Maybe—just maybe—it will be the model for a new style of drinking in BC.

Though the few that exist are popular, neighborhood pubs are not emerging quickly in British Columbia. The Dover Arms (above) is located in the midst of apartment towers in Vancouver's West End.

Dr Robert J. Gibbins

KINGSTON—Dr Robert J. Gibbins, of the Kingston branch of the Addiction Research Foundation of Ontario, died suddenly on March 17 as this issue of **The Journal** was going to press.

Dr Gibbins was one of the original members of the foundation's research division.

In 1952, he carried out its first major case-finding epidemiological study of alcoholism, the Frontenac County Survey, which was a landmark in its field. Ten years later, he directed a re-survey of the same county, in what must be one of the largest follow-up studies ever undertaken.

He was the author of the foundation's first book, *Chronic Alcoholism and Alcohol Addiction*, published as Brookside Monograph No. 1 in 1953.

Dr Gibbons established the ARF psychological laboratory which he headed for 20 years. He also established the analytical laboratory for street drugs and carried out valuable field studies of the "speed culture" in Toronto.

His premature death comes as a shock to his many friends in Toronto, Kingston, and other parts of Ontario who valued him as a person, a colleague, and a pioneer in alcoholism research.

'I have a healthy body'

By Thomas Hill

FORT LAUDERDALE, Fla.—Drug prevention efforts aimed at teenagers have been a total waste, claims Kerry Hart Stowell, who developed the viewpoint the hard way—through working in teenage drug programs in New York City.

Now the head of a company here named School Days, Inc, which produces and distributes unique health-oriented teaching material for young children, Ms Stowell is putting into practice her personal conviction that the prevention of juvenile drug abuse has to be started early in life.

"The reason why teenage drug prevention programs haven't worked," she says, "is that they reached the kids too late. The youngsters who were into drugs had a poor image of themselves, a poor self-concept. They couldn't say no to peers."

The principal objectives of Ms Stowell's *I Have a Healthy Body* program for young children are to help them develop a strong sense of self-concept and an appreciation and understanding of their physical selves. Her program consists of a series of kits, each containing a tape cassette, 30 copies of a related coloring workbook, and a teacher's guide.

The tape recording contains catchy tunes and clever lyrics designed to lead youngsters from three to eight years of age in a series of exercises and teach them that it's fun to have good health "and feel good all day long".

Besides helping the children to develop physical coordination, the lyrics, music, and exercises teach them on several levels: They learn new words, numbers and, above all, an awareness of the importance and joy of keeping their bodies healthy.

The lyrics often contain words and phrases that youngsters think are funny, like "my yummy tummy" or, as it's rendered on tapes translated into Spanish, "una barriguita exquisita".

Says Ms Stowell "Our feeling is very strong that we have to start each kit with a commercial—a self-commercial:

'I have a healthy body
My body belongs to me
And I can do most anything
Just you wait and see!'

"We implant the idea that 'I've got a wonderful body. I'm terrific. I'm marvellous. I'm going to take care of my body and this is how I'm going to exercise it—exercise it every day'."

Different kits cover muscles and bones; nutrition; digestion; respiration; growth; the senses; and other health-related topics.

The program contains no mention of drug abuse, not even a subtle one.

"This is important," Ms Stowell told **The Journal**. "You can't tell a young child to do one thing and not do another because you don't know what message he'll take home with him. We felt our approach had to be a positive one—'You're wonderful. You're marvellous.' When the teacher gets into discussion with the children later, that's something else."

Ms Stowell contends that if a child develops a good self-image early in life, and becomes aware of his entire body and strives to keep it healthy, he or she will maintain a positive outlook on health throughout his life.

"I'm not saying he'll never experiment with drugs but he will be easier to pull out if he does, because of a good self-image."

In the approximately two years since she put her kits on the market, Ms Stowell has seen their use grow rapidly. They are now used in schools in 40 of the 50 states and have been adopted by state education authorities in five states, including California.

One school in Canada has recently adopted the *Healthy Body* program—the Hawthorne Bilingual School in Toronto. There have also been some private trials of the program in other parts of Canada, although it is not widely used north of the border.

Although Ms Stowell has produced the materials in Spanish she hasn't yet made French language tapes and books.

"We haven't found out yet whether they're going to take in Canada," she says. "There'll be time to do them in French when we know there's a demand in that language."

The *Healthy Body* materials are, however, being used in Frankfurt, Germany. This results from a US government order for children of American military personnel.

Ms Stowell says when the programs are used in classes with approximately equal numbers from Spanish- and English-speaking families, a further valuable learning experience is gained. In such cases the teacher can play half of a tape in one language and half in the other and all the children begin to understand words and sentences in the less familiar tongue.

Ms Stowell stresses the program was not developed casually. From 1969 to 1972 she studied health programs in the US, Europe, and the UK, and decided none was reaching children in the crucial first few years of life, when 80% of learned habits and self-concepts are formed. Nor were the programs reaching children at their level, using words they could understand and relate to their own bodies.

With the aid of advisers in such fields as child psychology, health, and nutrition, she developed the *I Have a Healthy Body* program concept. In 1972 the program was born. Then it was tested for two years by 150,000 children in 13 states.

"A follow-up study showed teachers and parents were generally enthusiastic and we began to introduce the program elsewhere. It was clear ... the children were grasping the concept that good health habits are fun. We believe these good health habits can replace the 'need' for drugs, alcohol, and indiscriminate self-medication upon which so many adults depend."

Children are the focus of School Days Inc., a company established to produce health-oriented teaching materials for schools across the US and Canada. Drug prevention efforts are incorporated into the program by encouraging the children to keep their bodies healthy through an understanding of their physical selves.

Kerry Stowell

Tight money/ more alcohol use

Drinking fluctuates with economy

By Joseph Grimm

DETROIT—Per capita alcohol consumption and cirrhosis mortality rates are a function of long-term affluence or short-term stress caused by economic recession according to a Johns Hopkins University researcher. Dr M. Harvey Brenner, PhD. reported his findings recently at the University of Michigan's Mental Health Research Institute.

Dr Brenner believes long-term increases in real personal income in the United States are related to increasing per capita alcohol consumption. Short-term fluctuations in the economy, on the other hand, are inversely related to alcohol consumption and cirrhosis mortality rates.

He says the relationships are clear but a causal linking of the state of economy to alcohol use has not been established.

According to Dr Brenner, relationships can be seen most clearly in the use of distilled spirits, which has increased steadily as personal affluence has increased, but which fluctuates inversely to the immediate state of the economy. Beer and wine use also rises over long periods of rising affluence, but tends to rise and fall with the economy, Dr Brenner found.

The reason for the use of distilled spirits in this way is that Americans have learned about the anesthetic qualities of alcohol and use it as a stress-relieving drug, said Dr Brenner.

When there is short-term economic stress, as indicated by drops in employment or real personal income, per capita use of alcohol in general increases. When this stress is relieved by economic advances, per capita alcohol consumption decreases.

Cirrhosis mortality rates do not have such immediate relationships to short-term changes in the economy, but follow the fluctuations in abont two years. Dr Brenner reported that even during prohibition, economic recession was followed by these increases in cirrhosis mortality rates.

Using three-year time lags between economic recessions and fluctuations in cirrhosis mortality rates, Dr Brenner said he was able to account for 98% of the variance in these trends.

He noted cirrhosis does not normally develop in just two or three years and said increased cirrhosis mortality rates were probably the result of increased alcohol consumption by people with already-developed cirrhosis. Thus, cirrhosis is seen to develop more quickly during recession times than during stress-free periods.

Dr Brenner also found relationships between short-term changes in the economy and other indicators of alcohol use.

He said first admissions to state mental hospitals in the US for alcohol psychosis and for all alcohol-related mental disorders increase two years after employment or personal income recessions abont the same time lag he reported for increases in cirrhosis mortality rates.

Dr Brenner said the divergent effects of long and short-term economics and the different use patterns for distilled spirits and beer and wine suggest there are at least two different populations to be considered.

He also said the population that increases its drinking during recessions is the group whose members come into contact with the criminal justice system and who die of cirrhosis during those times.

Dr Brenner's work has been published in *The American Journal of Public Health*.

John B. Macdonald

Macdonald to lead Ontario's ARF into next phase

AN ADMINISTRATOR with a scientific background will lead the Addiction Research Foundation of Ontario into its second quarter century.

Dr John B. Macdonald will become the provincial agency's first president and chief executive officer, effective Sept. 1. At the same time, H. David Archibald, executive director of the ARF since its inception in 1949, will become executive vice-chairman of the foundation's 12-member board of directors with responsibilities for external activities.

The announcement, issued by ARF board chairman Larry C. Bonnycastle as 1975 drew to a close, followed two years of intensive internal and external criticism, review, analysis and reorganization.

An overhaul of the ARF was recommended in February 1975 after a 21-month study by Horace Krever, a University of Toronto law professor, concluded that a "desperate state of morale" plagued the agency. (See **The Journal**, *March, 1975).*

(The ARF employs 741 staff throughout Ontario at an annual budget of approximately $16 million).

Dr Macdonald, who comes to the ARF from the Council of Ontario Universities where he has been executive director since 1968, joined the ARF's board of directors almost two years ago.

Since his graduation from the University of Toronto in 1942, he has had an outstanding academic and administrative career.

He received his PhD from Columbia University in 1953 and went on to hold such appointments as professor of bacteriology, University of Toronto; professor of microbiology and director of postdoctoral studies, Harvard School of Dental Medicine; and chairman of the board of the Banff School for Advanced Management.

Dr Macdonald's research career in the field of microbiology took a major turn in 1962 when he took on the job of president of the University of British Columbia. He held this position until 1967 when he conducted a major study for the Science Council of Canada and the Canada Council dealing with the role of the federal government in support of research in Canadian universities.

While Dr Macdonald claims no expertise in the alcohol and drug dependence field, his interest in addictions goes back 30 years through a friendship with Dr Gordon Bell, founder of the Donwood Institute. He has served on the Donwood board of directors for nine years and was its chairman for three years.

He was a consultant to the ARF for a number of years and was active in the planning and development of the foundation's Clinical Institute.

In a recent interview with **The Journal**, *the foundation's president-elect made it clear his number one priority involves the development of an institutional sense of purpose about the ways in which the ARF uses its resources most effectively.*

'The practical problem is that ARF is going to have to limit its resources'

By Gary Seidler

TORONTO—The most important issue facing the Addiction Research Foundation of Ontario is the need to develop a common sense of purpose, according to the government agency's president-elect.

Dr John B. Macdonald spoke pragmatically about the need to develop priorities and bring a sharper focus to the work of the internationally-acclaimed foundation.

While he acknowledges problems of drug abuse are related to the whole question of lifestyle, Dr Macdonald does not visualize the ARF broadening its mandate.

"As a backdrop to immediate problems created by alcohol and drug misuse, we have to be conscious of the total context of what constitutes a healthy life . . . for the individual and society.

"Looked at that way, the ARF's mandate is universal.

. . . "But the practical problem is that the ARF, like any other organization, is going to have limits to its resources and if it disperses its efforts to dabble in a whole range of activities, it won't be very effective."

Dr Macdonald said it is clear governments have gotten into a position of overextension.

"Because ours is an important health area, we will continue to get government support," he said. "But it would be unrealistic to expect unlimited resources."

Dr Macdonald observed that one of the difficulties within the organization he will head is "a strong commitment of individuals to do their own thing".

At the same time, he said he was impressed with the quality of people at ARF and does not want to make firm judgements until he has had ample opportunity to discuss issues with staff who have the knowledge and expertise to assist in the development of a clear sense of purpose.

Scientific research, Dr Macdonald made clear, will continue to play an important part in the organization's future.

Encouraged by recent external audits of the foundation's research efforts, Dr Macdonald said the need is to identify programs of biological, behavioral, and social sciences research which will be most likely to be productive in terms of providing solutions.

As far as the foundation's regional programs are concerned, he is convinced the basic purpose of the organization's community effort should be catalytic. (The ARF operates 35 centres throughout Ontario).

"We need to develop in the community adequate resources to deal with the problems and then help make those resources independent as quickly and as effectively as possible.

"We must assist communities to develop their own services, under their own auspices. Once that is done, there are many new fields to conquer, many areas that have no resources at all."

Dr Macdonald said he suspects there is sufficient knowledge within the ARF to develop patterns which describe the kinds of resources most likely to be effective.

He indicated the time has come to provide standardized profiles of resources in communities.

"I appreciate the value of diversity in the absence of knowledge, but would wonder if, after 25 years, the ARF hasn't learned enough to promote standardization," he said.

In the area of professional education, Dr Macdonald visualizes a similarly catalytic role for the foundation.

"It is the foundation's responsibility to provide training opportunities for professionals who work in allied fields . . . physicians, nurses, social workers, psychologists, psychiatrists . . . people whose education experiences have paid little attention to problems of addictions."

With respect to public education, Dr Macdonald said primary prevention programming with the object of modifying behavioral patterns is crucial to counterbalance the bombardment of messages which encourage people to consume increasing quantities of alcohol.

"If we're going to be successful in primary prevention, we're going to have to give the general public a much better understanding of what's involved in the use of alcohol.

"I feel this starts in the schools. We have an opportunity to provide good information to schools, to assist teachers, school boards, and the ministry of education in seeing that health is taught more effectively."

In effect, he said, the foundation should be in the business of "wholesaling education".

Cocktails make fat -and heart disease

By Jean McCann

TUCSON, Ariz. — Alcohol abuse plays both a direct and indirect role in raising cholesterol in the blood, which in turn results in cardiovascular disease.

However, the direct effect of alcohol—in making people too fat—is probably the most important, Dr William Connor, professor of medicine, University of Oregon Health Sciences Center, said here.

"The average person who takes two drinks a day, and consumes on the order of 250 to 300 calories this way, is adding enough calories over a 10-year period to make him very fat indeed", Dr Connor told **The Journal** at a science writers' seminar sponsored by the American Heart Association.

"As a contributor to the total caloric intake of Americans, alcohol is important, because so many are overweight, and alcohol is a contributor to that.

"We also know that in some individuals, alcohol does cause a rise in the blood fat concentration but, over the long haul this may not be too important in itself.

"Of course liver metabolism is very important, and alcoholism does produce a fatty liver. I also think that with liver damage there may be impaired clearance of fat particles from the blood."

On the other hand, while the liver may overproduce cholesterol during some phases of alcoholism, for instance during the phase of alcoholic fatty liver, this is not true later on. As the liver becomes very diseased with cirrhosis, it probably underproduces cholesterol so, in the late stages, alcoholics probably have lower levels of the blood fats.

"At this point this doesn't mean much, of course, because they're at a stage where they're going to succumb, ultimately, from the cirrhosis."

In another talk at the meeting, Mr Mary Allen Engle, professor of pediatrics at Cornell University Medical College, and director of pediatric cardiology at New York Hospital, stressed heart disease prevention in childhood.

"Excess intake of calories and of salt, and the promotion of exercise and reasonable diet" are important, he said.

While advocating the promotion of lower blood fats by suitable diets, Dr Engle did not urge drastic changes in diet, except perhaps for those individuals with genetically high levels of blood fats.

This was in disagreement with Dr Connor, who advocated considerable change in the American diet to keep blood fats low. In addition to avoidance of alcohol, he suggested the use of polyunsaturated fats, elimination of most dairy products except for skim milk, and eating only a small amount of meat.

A typical breakfast, he suggested, could include cooked cereal, citrus fruit, and whole wheat or rye toast. Lunch could be a sandwich of peanut butter, olives, tunafish, or tomatoes and lettuce, plus a non-meat soup. Dinner would be fish or chicken, with vegetables, or in a casserole dish.

And no cocktails before dinner.

Time, gentlemen - - - Time!

By Tim Padmore

VANCOUVER — A British Columbia provincial judge armed with a stopwatch recently threatened to take action against anyone delaying proceedings in a prosecution of 19 people charged with conspiracy to traffic in heroin.

Judge John Davies was informed that the drug prosecution, estimated to be costing taxpayers $10,000 a day, could run as long as a year. So, he threatened to have defence lawyers replaced and to revoke defendents' bail if they do not arrive on time.

The court's declaration came after one lawyer and one of the accused failed to arrive in time for the 10 am opening of a preliminary hearing.

Judge Davies uses a stopwatch to time adjournment periods.

Only two of the accused have retained lawyers. The other 17 have qualified for legal aid lawyers, costing the provincial and federal governments an estimated $100 to $200 per day per lawyer.

Former attorney-general Alex Macdonald said last fall that the success of the Co-ordinated Law Enforcement Unit in snaring drug traffickers is causing dramatic increases in court costs.

Heroin couriers, who used to carry large amounts of money, are now being found without funds when arrested and are applying for legal aid, he said.

Drugs exploit poor

PONTIAC, Mich.—A new study by the National Council on Drug Abuse shows over-the-counter drugs tend to exploit those people least able to cope with the drugs' effects and complications.

Jordan Scher, executive director of the NCDA, said the poor, the elderly, the divorced, and the emotionally disturbed —the alienated in society— are the ones who are suffering the most from OTC drugs.

"Since these persons often do not have ready access to medical care, they try to self-medicate. They compound and complicate already-existing medical or emotional problems in this way.

"The OTC drugs stimulate a sense of physical health in these individuals and they thus put off getting prompt medical attention," he said in a speech to the Michigan Center for Continuing Education Conference on Substance and Alcohol Abuse.

Dr Scher added: "The OTC drugs mask the real illnesses, whether physical or emotional, and prevent accurate diagnoses by physicians when these people finally do seek out medical care."

"The almost certain complication of OTC drug use is something not to be minimized or overlooked by physicians. Of course, the financial burden of purchasing largely useless and merely harmful OTC drugs is the final blow to those who can least afford it, and its exploitative factors should not be ignored by the concerned physician," he said.

Halfway houses right on target

Feature stories by Betty Lou Lee

AFTER AN initial halting and a frustrating two years, the province's network of half-way houses to back up non-medical detoxification centres is right on target.

"By the end of March, 17 houses were being funded, and by June, we'll have another five," says David Pitt, coordinator of adult group homes and half-way houses for the rehabilitation branch of the ministry of community and social services.

"In the initial stages, we were well behind the eight ball. Now we've caught up with and passed the detox centre program. It's been a helluva struggle and there's been a lot of flack. At a couple of points we were ready to scupper the program. When the money is there you have to use it, or you lose it."

The provincial government pledged $4.5 million over three years in July, 1971, to set up a system of detox centres and half-way houses in each judicial district where there were more than 1,000 arrests a year for public drunkenness.

The program was a pioneering one, based on a pilot project set up by the Addiction Research Foundation that showed detox centres didn't need medically-trained staffs and sophisticated equipment.

The program called for 16 detox centres, each with half-way houses or other rehabilitation facilities, to be established by 1975.

Fourteen detox centres are now operating, says Dr Jean Moore of the ministry of health, but the other two won't open this year. One was to be affiliated with Toronto General Hospital, and the other located in Pembroke. "Hopefully, we can get them next year."

Different funding approaches taken by the two ministries were in part responsible for the slow start in the half-way houses. The health ministry finances the detox centres with the money administered by the hospital that serves as the centre's medical backup.

The community and social services ministry provides only 80% of the financing for half-way houses that meet its charitable institutions requirements. All of the houses now being funded were in operation under other auspices before being part of the program, and there were delays before they could meet physical requirements like fire regulations, and get adequate staff.

"Since we only funded for 80%, we needed a non-profit organization to raise the other 20% in the community," says Mr Pitt. "If you start planning now, it takes 15 months before the thing gets off the ground."

By June, half-way houses will provide 359 beds. That part of the program cost the ministry $1,061,400 in the fiscal year that ends April 30.

The health ministry's budget for the 14 detox centres with about 300 beds is $2,386,200 for the same fiscal year.

Both Mr Pitt and Dr Moore express a lot of satisfaction with the way the programs are going, and both are looking forward to an independent assessment by the ARF which is doing a three-year follow-up of results.

"Our primary concern was would we get the staff of the calibre we needed, and would they stay," says Dr Moore. "We were fortunate to get people with the interests of the man at heart.

"The original concept was that we would give people a safe, comfortable place to detoxify, and motivate them to seek ongoing help. The original set-up was to enable the police to bring alcoholics in, but the centres are gradually becoming more community-oriented so that the percentage of beds reserved for those brought by the police may vary from 25% to 100%. Many come back on their own, others are brought by Alcoholics Anonymous members or sent by hospitals. It has become much more a community program than originally intended, and I think that's a good thing.

"We've been very lucky with staff members. Some units started with 50% of the staff recovered alcoholics, and some are up to 75%."

In 1975, the detox centres had 25,677 admissions, almost half of them brought by police. They stayed anywhere from four hours to 10 days, and 5,995 individuals accepted referrals to a wide range of services—half-way houses, AA, hospital rehabilitation programs, Canada Manpower, vocational training, and social services.

"All the centres have at least 100 to 200 men who are staying sober, depending on how long they've been open," says Dr Moore.

Costs are running from $18 to $25 a day, depending on the size and location of the centre.

The original estimate based on the pilot study was that only 5% of people in a detox centre would need medical care. That has proven pessimistic.

"Most units are finding that it's 1% or 2%," says Dr Moore. But there is careful selection of who is admitted. The centre will not accept a drunk who is unconscious, is having DTs, or is known to have pneumonia or diabetes, for example.

She says it's surprising what a difference it makes to take drunks out of a hospital setting.

"They aren't told to do this or do that—they don't like to be ordered about. I heard of one man who started to shake when he sobered up at the centre. Someone next to him said 'You don't have to do that, they'll keep you anyway,' and he immediately stopped, sat up, and had a coffee. We've also had fewer epileptic seizures than we expected."

Most of the centres have been established in older houses. The only one being built specifically for the program is a 40-bed centre in Kenora for both men and women that is expected to open in May at an estimated cost of $420,000.

It will not meet the total need in this community where Indian drinking is a major social problem, but Dr Moore notes that Indians are more active in setting up programs within the reserves.

"This will be a tremendous help and take the pressure off the Kenora facilities."

Ask Mr Pitt where his big problem area is, and he answers without hesitation: "Toronto—where all the resources should be.

"Toronto is so big that when you get into fundraising you're lost unless you're tied into a church or some other organization. There are now four half-way houses in Toronto in the program, including one for women, and the ultimate goal is six.

"In a community with 23,000 arrests for public drunkenness a year, we're grossly underserved."

Kenora is another problem area for half-way houses, and the ministry waived its 20% community funding rule there. An 18-bed house opened last June. "It's not large enough but it's a start, and we're going cautiously. We don't want it to be a flophouse."

Speaking generally of his satisfaction with the program so far, Mr Pitt says: "It's so elementary that for years it eluded the sophisticated minds that wanted fancy treatment centres.

"It's low cost, it's close to the community, and it simulates the conditions these people will return to. It is directed at the Skid Row population with the least chance of rehabilitation, but a lot more than the Skid Row types are now using it.

"It has a lot of desirable features, and one of them is that the lay person sees the drunk as someone who lives in a house, not a jail, a hospital or a psychiatric hospital."

Hamilton's detoxification centre is 'reeling off success stories'

HAMILTON—*"We feel if we help get 15 men a year sober, this place pays for itself. We've got 148 men with a year's sobriety and 37 with two years or more, after being open three years."*

The speaker is Bob Melway, director of the Hamilton detoxification centre, and he reels off success stories with the enthusiasm of a man in love with his work.

"We're just the starting point," he's quick to point out of the centre's role in getting a Skid Row drunk back on the rails.

"But the savings to the community are fantastic. Someone estimated that it saves society $10,000 a year when a drunk gets sober and back to work."

Mr Melway's real gauge of success of the centre isn't in dollars and cents, however. It's in individual stories like that of the record-holder for return visits. That man came back 14 times in the first six months of operation. After years on Skid Row, he's now one of Mr Melway's most valued staff members.

Or there was the guy from Nova Scotia, 3½ years a derelict. Mr Melway took him from drunk court as an alternative to a 30-day jail sentence. He opted to go to a half-way house from the centre, and stayed sober for a year until the director lost track of him. Recently he learned the man was back in Nova Scotia, a painting contractor with 35 men working for him, and with 19 months of sobriety under his belt.

"It was fabulous," says Mr Melway.

The centre has had 4,990 admissions involving 1,723 men in its three years, and only 1.6% of them have required admission to Hamilton General Hospital which administers the centre but is blocks away from it.

"Most of them were cases of pneumonia or blood poisoning."

The daily cost per man in the 20-bed centre is about $15, compared to more than $100 at the General and $32 in jail. Total budget last year was $140,000 which included rent, food, and wages for the nine paid staff.

Mr Melway attributes the high rate of sobriety among the centre's users to the community back-up services. "We've got the finest back-up in Ontario here. We're very fortunate."

There are three half-way houses, plus other missions and rehabilitation services. There is also a 21-day hospital treatment program for alcoholism.

Most of the larger employers in the industrial Steel City use the centre, and many have rehab programs for alcoholic employees. AA plays a big part, and a public health nurse holds discussion groups three times a week at the centre and counsels families of alcoholics.

Of the 140 to 150 men who go through the centre each month, only about 10 go to half-way houses.

Hamilton is not alone in its success with the men on the bottom of the drinking totem-pole.

Ron Brown, director of the West Central Detoxification Unit of Toronto Western Hospital, says that close to 4% of the men who've been to his centre in the last four years have been sober for at least 12 months. That represents 280 lives.

Raymond Duncan, director of the Waterloo Regional Centre, knows of 92 men who've been sober for a year among the 646 who used the centre in its first year of operation. Those men accounted for 1,614 admissions.

While 3% of the men are professionals, the average one is a 45-year-old, white, high-school dropout who works about half the year at laboring or unskilled jobs, and has been on welfare for six months.

He's the father of two children, but is separated or divorced, and has little contact with his family. Booze is his only drug and he uses it daily, but has had little treatment for alcoholism.

Mr Melways says although alcohol is the major problem, "we're seeing a lot of cross-addiction in the older men and it all started in a doctor's office with Valium, Librium and Seconal .... We're just death against it.... We don't blame doctors, but we wish they had more knowledge about alcoholism. Drugs are just another drink if they are mood- or mind-changing.

"A doctor wouldn't give him a bottle of liquor, but he'll give him a bottle of pills. Most of the deaths we see are from a combination of drugs and pills."

Writer wins award

HAMILTON Betty Lou Lee, one of The Journal's Canadian correspondents has received the $1,000 Ortho Medical Journalism Award for 1975.

The award is presented annually to the person or persons considered to have made an outstanding contribution to medical journalism in Canada through an article or series of articles in print. It was presented to Ms Lee at the annual meeting here of the Canadian Science Writers' Association.

Betty Lou Lee

She received the award for an article on the development at the University of Toronto of an artificial pancrease for diabetics. The article was published in February, 1975, in The Hamilton Spectator.

Ms Lee, medical reporter on the Spectator, has also been elected president of the Science Writers' Association. She has been a correspondent for The Journal since this newspaper's inception.

The award is provided by Ortho Pharmaceutical (Canada) Ltd.

Frederick Glaser

"There is an endless proliferation of individual and entrepreneurial programs operating in splendid isolation from one another"...

... "There is a general belief on the part of legislators that if we have to make cutbacks, addictions is an area to cut back in"...

... "Programs are not interconnected in any way and in many instances neither know nor care about the existence of other programs."

—Photos by Toby Barrett

In desire to cure

Caring component neglected

By Toby Barrett

TORONTO—An internationally known researcher now on staff at the Addiction Research Foundation of Ontario has charged that the field of addictions lacks any effective treatment system.

"There is an endless proliferation of individual and entrepreneurial programs" operating in "splendid isolation from one another," Dr Frederick B. Glaser told **The Journa**l.

(Dr Glaser is head of psychiatry in the ARF's Clinical Institute.)

Before joining the ARF, Dr Glaser was professor of psychiatry at the Medical College of Pennsylvania and, before that, at Temple University, Philadelphia.

In the early days of the drug scare, Dr Glaser joined the US Public Health Service Hospital in Lexington, Ky.

'KY', as it came popularly to be known, opened 40 years ago as the US Narcotics Farm and was once described by *LIFE* magazine as the "world's largest, oldest, most prestigious centre for treating drug addicts".

Today, Dr Glaser believes that in their often unrealistic desire to "cure" people, health care systems, particularly in the addictions field, have neglected to "care" for people.

And what most people need, he says, is care.

He believes the overemphasis on cure has dominated medical thinking up to the present time because of advances in surgery and treatment with antibiotics. But to deal with problems like alcoholism and narcotics addiction in "as sudden and as dramatic a way is simply untenable," Dr Glaser said.

In an effort to improve the situation, and for the Addiction Research Foundation and health care in general, Dr Glaser has developed what he terms the Core-Shell Model.

The model has two basic components—the core program and the shell program. Primary care, including assessment and research, is performed in the core while secondary care, in the shell program, is oriented towards cure.

Dr Glaser describes care as the "maintenance and control of a given problem at a more or less satisfactory functional level over a prolonged period of time". Cure, he says, is a "concerted attempt to eliminate completely a given problem in a relatively brief period of time".

Dr Glaser calls on government to provide a "supportive ecology" for the development of a systematic approach to treatment.

For the moment, however, he describes the existing approach as non-planned and evolutionary—an "entrepreneurial" or "proprietary" one that is the health services analogy of classic capitalistic economics.

"If you allow people to behave in terms of their own enlightened self-interest, the market situation is such that it will create an efficient system.

"I am not an economist," said Dr Glaser, "and I don't know whether or not this is true or was ever true in economics, but my experience is that it is not true in terms of health care delivery."

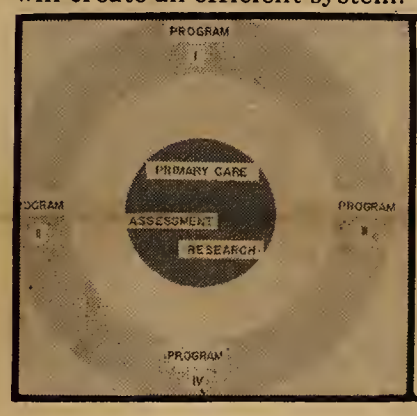
He also stressed the necessity at times, of financial stringency, for people in the addictions field to demonstrate "that what we're doing works. The alternative is, we won't be allowed to do it anymore.

"There is a very general belief on the part of legislators that if we have to make cutbacks, and it seems we do, addictions is an area to cut back in." The reasoning in this, he said, is that "people get themselves into these problems and, if worse comes to worse, they can jolly well get themselves out".

Describing the present approach as fragmented, Dr Glaser said: "Programs are not interconnected in any way and in many instances neither know nor care about the existence of other programs in the same community.

"They try to be all things to all persons with problems relating to alcohol and do not succeed, and it would not be reasonable to expect them to succeed."

Hence, the critical function of the Core-Shell Model is appropriate treatment referral.



Dr Glaser's Core Shell Treatment System proposes all functions of primary care. He feels there has been too little emphasis on care in health systems and an over-emphasis on cure. The model stresses appropriate treatment and referral.

"There is virtually no cross-referral in our present system," said Dr Glaser, citing a study by E. Mansell Pattison of 600 patients where not one treatment facility referred the alcoholic to another more appropriate program.

"It is inconceivable that in 600 instances there wouldn't have been at least one or two where somehow people got to the wrong program. As a matter of fact, I'm inclined to think that happens in about 90% to 95% of the cases," he said.

The Core-Shell Model incorporates an on-going restructuring of the assignment process. "Certain kinds of people do particularly well in certain kinds of programs. A good clinician knows this almost intuitively and all we are going to do is systematize that," Dr Glaser said.

"Through separation of the evaluative function from the treatment function it will be possible to alter the path of the cross-referral instantaneously. This is necessary because flexibility is essential—programs change and the population of people entering treatment changes."

Treatment is a complex task, and thus Dr Glaser's model incorporates the division of labor as its essential characteristic. Referring to general practitioners, he said they are expected to do everything — primary care, treatment, assessment and research.

"Generally speaking they do very well in providing definitive intervention because very largely that's what they're trained to do.

"But, they don't do very well providing primary care or assessing people. By and large, practitioners are not trained to do research and they don't like research—research is not congenial to treatment.

"Even if treatment people do research, it tends to be biased because they tend not to do the kind of research which challenges their own basic assumptions.

"It's a very human sort of thing. The treatment research literature is chock full of studies which have the 'Aha' quality like 'I knew it all the time and now I've proved it'. Whenever you see that you have to be suspicious."

The Core-Shell Model requires research to be done from a central vantage point and not to be subject to such biases.

It stresses research-oriented follow-up studies, not on a one-shot basis as is now the case, but done "continually and longitudinally".

"These are not merely to be published in an esoteric journal for the delectation of other academics and the professional advancement of researchers."

A self-correcting, dynamic model is proposed that provides treatment possibilities "complex enough to match the complexities of the problem".

Only by breaking down the functional components and putting them in their proper order "as in the assembly line", can a system be created that will fulfill the task.

"People find industrial comparisons odious but the fact is they are extremely useful," Dr Glaser said.

"We don't mean to dehumanize it — systems do have their problems but if you are going to do a complex task at a high level of output that's what you need to do."

'You have to make people react'

(Continued from page 1)

(In January health minister Bob McClelland fired the six-man commission appointed by the New Democratic Party. The minister recently named Narcotics Addiction Service executive director, John Russell, and John Haig, a specialist in alcoholism with the health department, to complete the new three-man commission.)

Mr Hoskin told businessmen attending a fund-raising dinner for the Richmond Alcohol and Drug Abuse Team that programs to help the province's 80,000 alcoholics and 12,000 heroin addicts will be developed in two phases.

In the first phase, which will last about a year, changes will include:

- Giving intensive help to users who seriously want to quit;
- Carrying out a trial, low-cost methadone program for addicts with "no measurable" motivation to be drug free;
- Supporting innovative addiction treatment programs, particularly ones that don't rely on drugs of any kind;
- Setting up separate programs for beginning users and hardened addicts;
- Consulting with the attorney-general on possibilities for compulsory treatment of addicts and alcoholics in detox units.

Regarding the latter, Mr Hoskin said: "If we are to relieve the police of a responsibility which is not rightly theirs, we can do little to help them and the alcoholic if it's a case of in the front door and out the back."

He did not explain what would happen in the second phase, saying only that a plan would be developed with the help of a committee including representatives of the departments of health, education, human resources, and the attorney-general, and of the medical profession, and implemented, possibly next year.

But, asked in an interview to spell out his views on what shape that plan should take, he offered a copy of an unpublished proposal he wrote in 1974, and distributed at his own expense to people involved in addiction treatment.

"Some of the things I say in there may sound pretty strong, stronger than I might put them today," he cautioned, "but you have to make people react."

In the paper, Mr Hoskin proposes registration of narcotics and cocaine users; compulsory laboratory testing for abuse; and compulsory treatment and imprisonment or isolation of addicts.

Acknowledging this will offend people sensitive to invasion of human rights, he argues that "current methods of control and proof of possession are far more punitive, and current voluntary and custodial treatment programs far less effective than what is proposed."

He holds little hope for the "older, habitual" user, saying therapy should be offered only if an addict co-operates fully with the program selected for him. A "history of repeated abuse" or refusal to co-operate would bring imprisonment for an indefinite period, with yearly review or isolation in a remote user commune.

He recommends the user-trafficker be given a similar, but somewhat harsher option—treatment, or life imprisonment with no parole.

Mr Hoskin calls for a massive effort to cut off supplies of marijuana and proposes stiff prison terms for pot traffickers. Users would get off with a warning the first time, but a second offence would mean compulsory treatment or imprisonment.

Mr Hoskin acknowledged that full implementation of the program he proposes would involve changes in the Criminal Code of Canada, and expressed the hope that a federal provincial conference will be called to discuss drug issues.

He said that as the province moves into "phase two" the commission may be dissolved, and the programs taken over by the health department.

"I figure this is my year. If I can get to the end of the year and accomplish something, I'll be satisfied."

Mr Hoskin also said the commission is reversing the policy pursued under the NDP government, of supporting programs initiated by the community, and will itself try to determine what kinds of programs should be set up.

Evidence of the changed policy is the fact that 10 agencies have been cut from the list of 52 supported by the commission last year and no new agencies will be funded.

UK guide leads non-smokers to good food

LONDON—For the first time, one of the major British food guides has listed restaurants where efforts are made to discourage smoking by diners.

The list is contained in the 1976 issue of *The Good Food Guide*, which is published by the Consumers' Association. Editor Christopher Driver said he felt many other restaurants would like to be on the list—if they dared.

He said a major difficulty is that very few of the 1,200 restaurants in the guide are able to separate their smoking and non-smoking areas. Nor can many afford to install air conditioning equipment to mitigate the problem of smoke.

Mr Driver said he favors a smoking ban in all public eating places. He felt there would be no significant loss of customers if smoking were not allowed before 2 pm for lunch or 9 pm for dinner.

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It's back to square one

The current upheaval in British Columbia (see Page 1) is a perfect example of just how vulnerable drug programming is to the whims of politicians.

Out goes one government (the left wing New Democratic Party), in comes another (the right wing Social Credit), and with that transfer, the whole approach to drug abuse does an about-face.

The six-man commission appointed by the previous government is mercilessly swept away, and with it go many of the policies and programs that had been devised.

Recent statements attributed to BCs new drug chief Bert Hoskin clearly show that here is one province that has had enough of 'permissive' drug programming, and that the big stick is once again coming out of mothballs.

By advocating compulsory treatment of addicts coming before the courts, registration of addicts, and compulsory testing of abusers. Mr Hoskin reveals a hard-line approach that is a radical departure from trends being developed in many other jurisdictions. It also differs markedly from trends refined by the previous administration.

Just because this new approach differs, does not mean it is inappropriate — only the people of BC can ultimately judge the appropriateness and effectiveness of drug programming in their province.

But what is so disturbing is the erratic nature of the link between drug programming and policies.

Was BCs drug programming initiative of the early 70s scuttled because it had no merit, or because it was born of a government out of office and out of favor?

If the latter, then what's the purpose of trying to develop long term social policies in respect to drug and alcohol abuse? If every change in government means we go back to square one in terms of delineating our priorities and staffing our institutions, then all we succeed in doing is recycling our mistakes.

In the early seventies, US street crime was raging, veterans were returning from Vietnam with stories of rampant drug use, and the administration of Richard Nixon saw political gains to be made from the issue of drug—heroin—abuse.

The effect was that millions of dollars were diverted to the issue, and a whole bureaucratic superstructure was set up to obliterate heroin use and its sequelae in the mainstream of American life.

There is no question that without that instant priority, drug abuse programming today would not be in nearly the state of advancement it enjoys.

Without that federal commitment we would not have the treatment, training, and research activities that have characterized recent growth of organized drug abuse responses.

The Special Action Office for Drug Abuse Prevention (SAODAP) may have been set up largely for political reasons, but the fact is that it left a legacy of considerable substance.

But as political priorities rise, they can also fall— precipitously, and therein lies the danger of drug abuse programmers crawling into bed with with the pols.

When the Nixon administration began talking about having turned the corner in its war on drugs, funding too turned the corner. The people and agencies across the country who had been exhorted to more and greater activity were suddenly pulled back into reality and told to wind down some of their activities.

There was confusion, frustration, and a lot of subsequent mistrust.

Whatever momentum had been built, fell apart as political priorities changed.

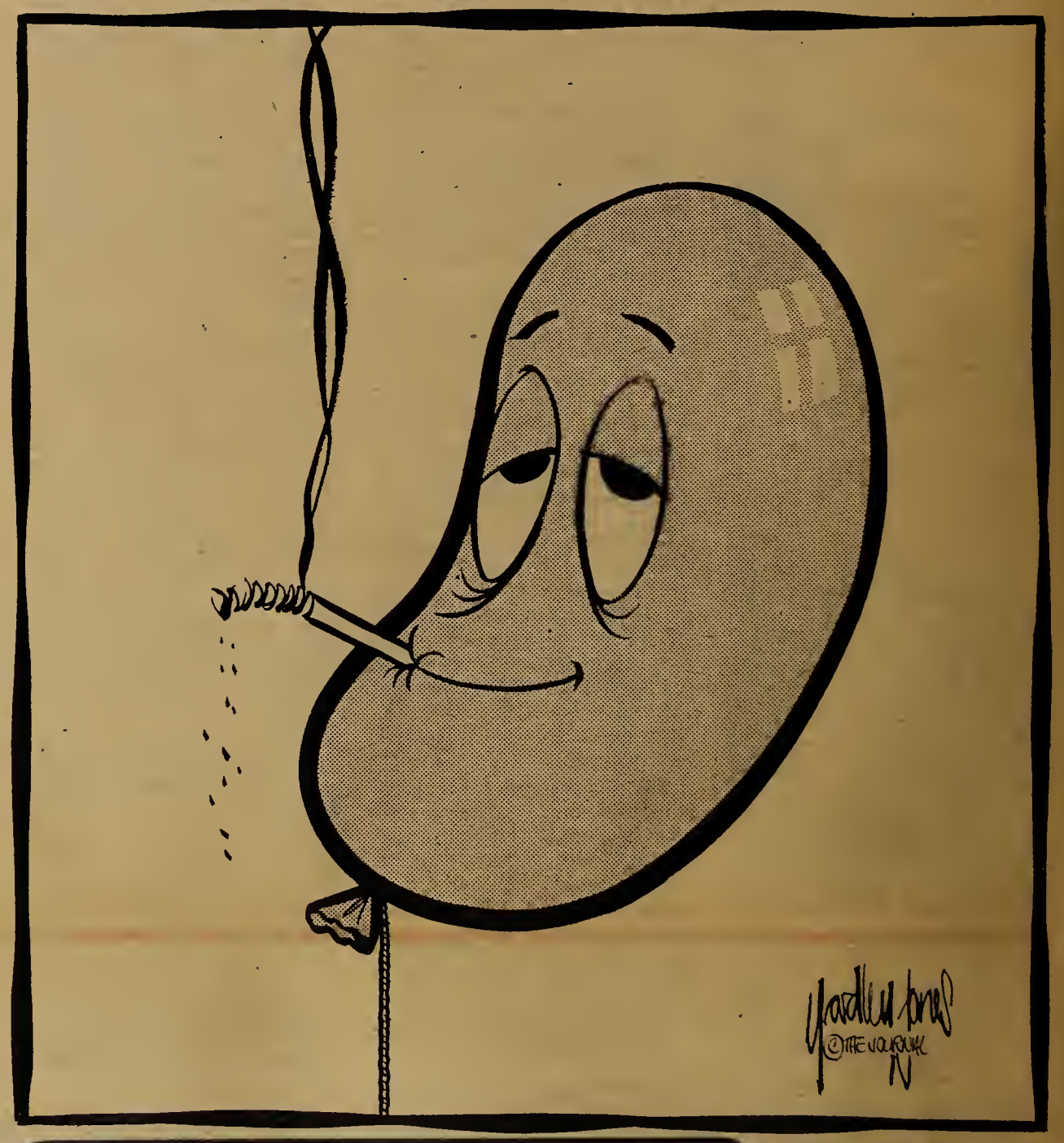
Now we simply cannot get around the fact that as governments change, priorities will change too. But must the change always be so catacylsmic? Must opposing parties always try to wipe the slate clean? Is there nothing to learn from experience?

If drug abuse programming is to be something more than a band-aid, there has to be some assurance of continuity, some overall policy delineating the role that drugs are to have in our lives.

We are not likely to develop and articulate a policy if we continually seek to wipe out the gains of a previous administration simply because political ideologies don't mesh.

We have to ask ourselves if we are out to obliterate drug use, to tolerate some use, or to learn to live with abuse? Which functions should we leave to government and which to the private sector? We have to consider how much personal freedom and liberty we are willing to trade away in order to develop the means of enforcing our laws.

If we can articulate and enforce policies based on these kinds of questions, it seems we will all be less vulnerable to the hammers and tongs of political warriors. **M. K.**



Letters to the Editor

More letters — page 12

Sir:

The New York Conference on Chronic Cannabis Use has evidently impressed **The Journal**'s Milan Korcok. Of course, even the most casual student of the Addiction Research Foundation and **The Journal**, should not be too surprised at the March editorial urging us to show "imagination and initiative" as we progress with haste toward the enlightened inevitable — the total decriminalization of pot. Not too surprised, simply because the ARF in the past few years has manifested an increasingly benign disposition toward Cannabis to the point where, if we are to believe one who must be a Journal guru — Dr Nancy Rubin — "alcohol may have to go."

A few nights ago I attended a public meeting sponsored by the Ontario government (represented by MPP Terry Jones) and the ARF, I chose the occasion to point out that there was a disturbing inconsistency between concern over the increasing consumption of alcohol by adolescents and the view that we possibly "cannot afford" not to "consider state and provincial boards" to control the distribution and sale of Cannabis.

It is generally acknowledged in the pages of **The Journal** that some decades ago, had we predicted the ravages caused by tobacco and alcohol, these substances would have been subjected to the harshest restrictions. It is astonishing that in spite of this incredibly valuable experience, Mr Korcok should still urge us to act as if we knew all the facts and all crucially important and complex questions had been fully answered.

Let us take only one controversy over Cannabis– the amotivational syndrome. The measurement of attitudinal change (which is the essential task required in examining the amotivational syndrome) is one of almost baffling complexity and the ability of the behavioral sciences to do so with any degree of precision lags very far behind their ability to speculate. Still, there are clues that the chronic use of Cannabis leads to a loss of motivation. There was an amusing one in Mr Korcok's September report on the Jamaican study, where a dozen workers were said to "work like demons" after smoking. This, naturally, was taken as evidence that ganga did not inhibit the work ethic. However, after a mere 15 minutes, the workers required more "herbs" to get going again.

The more recent US Army study (reported in detail by Mr Korcok) claims not to support Kolansky and Moores's observations that chronic users were "apathetic and sluggish in mental and physical responses". The observations were corroborated by other clinicians such as Hardin B. Jones, Reese Jones, M. I. Soueif, Forest S. Tenant, Jr., and D. J. Groesbeck. Studies which do not demonstrate a loss of motivation are usually (e.g. Mendelson and Meyer) experimental situations where subjects are required to work, such as pressing a button, in order to obtain their reward a joint of marijuana. They cannot be taken to approximate life situations and the very fact that they *require* motivation on the part of the subjects means that they measure motivation and not the absence of motivation– this is a very important difference to keep in mind.

But, there are even more important reasons than the above why the call for the decriminalization of Cannabis is fundamentally irresponsible. What possible contribution can Cannabis make to our culture and to our civilization? As a sociologist, I suggest our present fascination with mind-altering substances, and our starry-eyed inclination to permit the use of one of them, is a regressive reaction to the radical changes taking place in society. The most powerful of

(continued on page 12)

Backgrounder

By Milan Korcok

WASHINGTON — Back in 1973, when President Nixon and some of his top bureaucrats were touting victory in the "war on drugs", sceptics were a dime-a-dozen . . . not just professional nags out to destroy administration credibility for the fun (and politics) of it, but people who ought to know.

The feds could pull out all the indicators, all the evidence that "the corner had been turned." They could show you that in certain critical centres such as the District of Columbia and New York, drug-related deaths, arrests, and treatment admissions had dropped.

The sceptics would just shake their heads and say "I know what I know".

What they "knew" was that a lot of people were hurting because of heroin, and that despite all the evidence being dragged out to substantiate "the end of the epidemic", a lot more people were going to get hurt in the future.

It turns out the sceptics were right, and the feds, who had all the evidence, were wrong.

When Dr Robert DuPont, chief of the National Institute for Drug Abuse (NIDA), went before a press conference in mid-March and admitted he had been wrong in generalizing too freely, he was affirming one incontestable fact about drug use in America today: It is endemic and becoming more widespread.

There may be periods of recession, there may be political or economic conditions that temporarily suppress use of heroin in some parts of the country at certain times. But heroin use has permeated so many segments of society, has broken through so many regional barriers, that to gauge its ebb and flow according to price, purity, and trading patterns in New York City and Washington, DC alone is foolhardy.

"I've learned my lesson . . . trends can change very quickly. They are much more volatile than I thought in 1973."

What Dr DuPont, and many other administrators and researchers saw in 1973 was a sharp reduction of heroin-related arrests, drug overdoses and emergencies in Washington, DC, then the "crime capital" of the US.

They also saw numbers of addict registrations in New York City treatment programs dropping, empty treatment slots, and quality of street heroin dropping and price rising—evidence that supply intervention was working.

It was encouraging but misleading.

New York City and Washington are not THE United States, and the kinds of intervention efforts going on in these cities were not taking place in other metropolitan areas. No holds were to be barred in cleaning up the nation's capital.

So while some politicians were taking sustenance from claims the country had turned the corner in its fight against heroin use, the signals were starting to accumulate that the heroin trade had just taken on a different shape, and what appeared to be a lull in use was only temporary..

Any hiatus caused by interruption of heroin through the French connection was soon to be terminated by entrepreneurs working out of Mexico.

While there were encouraging signs in New York and Washington, cities in the Southwest, such as Pheonix, were experiencing a surge of high-quality heroin trade.

By mid-1974, San Francisco, a trend-setter for the nation was once again seeing increases in heroin-related deaths, and in admissions to treatment programs, and was bracing for a return to addict waiting lines.

At this same time, Dr Mark Greene, a public health physician working on a NIDA commission was compiling startling data showing the spread of heroin use in Middle America.

He was documenting the existence of peaks of heroin use in cities such as Eugene, Oregon; Jackson, Mississippi; Austin, Texas; Greensboro, North Carolina; Racine, Wisconsin; Pensacola, Florida; Omaha, Nebraska and Boulder, Colorado.

Consequently, it took little time for Dr DuPont himself to become restive about the way some of his political bosses tried to capitalize on what was incomplete data. He surely would have given away his last pin-striped shirt to anyone who would forget he ever had anything to do with that fateful phrase "turning the corner".

The year 1973 does appear to have been a recessive period in terms of heroin use patterns during the past decade. From all indications, it was a low point. But the mistake was in thinking the recession was anything but temporary.

The data revealed by Dr DuPont, based on the Heroin Indicators Trend Report, shows that since 1973, the heroin use problem in the United States "has gotten progressively worse".

Whether it is worse than peaks prior to the 1973 recession is difficult to say as the data base at that time was sparse and unrealiable.

But the projection now is for a "worsening situation". The trend may not exhibit the same sharp, eruptive peaks that characterized heroin use in the 60s, but if it could be called epidemic use then, it can certainly be called epidemic use now.

"Yes," says Dr DuPont, "I would say the epidemic is continuing, and I would say it has never ended."

Dr DuPont's recent comments on heroin are considerably more substantive than his 1973 proclamations because there is a sounder data base. It relates to trends in the nation as a whole, not just trends in New York and Washington.

Washington-based newspeople are not a particularly gentle lot. So when one of them asked Dr DuPont what made this announcement any different from other "scare reports", he could justifiably claim more solid ground.

The model developed for measuring trends is clearly outlined in the Heroin Indicators Trend Report. It is a composite of data about drug-related deaths, emergency rooms, hepatitis, heroin price and purity, arrests, treatment admissions, and self-report surveys.

Each of these indicators, looked at separately, has loopholes and deficiencies.

But, NIDA hopes that when all these separate indicators are blended into one grid, they provide a responsible mechanism to track the relative measures of change.

Largely because of presidential intervention in the early 70s, heroin has become a political issue. It became a high priority item attractive to talk about.

It is still a political issue, except now it has to take its place in a long line of political issues. Resources are limited, people have become concerned about a great variety of drugs — not the least of which is alcohol. Now there are many more drug-oriented constituencies fighting hard for fewer dollars.

Drug treatment programs, which in 1972 and 1973 were proliferating, have now slowed to a crawl. The training of personnel for the drug abuse field is already suffering sharp cutbacks, and some segments of the highly-touted national training system are facing extinction.

Unless there are some pretty dramatic changes in political priorities and funding, the future does not look pleasant.

Inside Science

Dr Gilbert is a scientist with the ARF. This article is based in part on a chapter to appear in volume 3 of Research Advances in Alcohol and Drug Problems (Y. Israel et al, Eds) to be published by John Wiley Sons.

By Richard Gilbert

CAFFEINE IS the most widely used psychotropic drug in North America. It is used regularly by more than 90% of adults. Caffeine appears in coffee (30-180 milligrams per cup), tea (10-100 mg/cup), colas (20-45 mg/10-ounce can), chocolate bars (20 mg/ounce), wake-up pills (100-150 mg/pill), and some headache pills (30-65 mg/pill).

There is little evidence that harm is caused by regular consumption of moderate amounts of caffeine, i.e., about 250 mg/day for an adult of normal weight, especially if consumption is spread out over a number of hours and does not occur in the evening.

There is more evidence that regular consumption of amounts in the order of 350 mg/day can produce physical dependence on caffeine. Physical dependence on a drug is evident when regular use of the drug is interrupted and a characteristic withdrawal syndrome appears. In the case of caffeine, the predominant withdrawal symptoms consist of a headache and a feeling of irritable tiredness. They can be quickly alleviated by recourse to caffeine, including the caffeine that occurs in headache pills.

About 25% of the adult population of North America is physically dependent on caffeine. Physical dependence on a drug is not harmful in itself as long as the drug can be obtained. Harm can occur because of the disabling effect of withdrawal. The mood changes resulting from inadvertent caffeine withdrawal, for example, could be a contributing factor to traffic accidents. Harm can also occur because physical dependence involves the use of toxic quantities of a drug. In the case of caffeine it appears that physical dependence can exist without much danger to health. (There is little evidence that physical dependence is a cause of drug use. Where such dependence occurs, it often appears to be a by-product of drug use that continues for other reasons.)

Caffeine use probably begins to contribute significantly to the health problems of an average adult only when regular consumption exceeds 600 mg/day. Consumption above this level has been associated with sleep disturbance, chronic anxiety, ischemic heart disease, gastrointestinal ulceration, bladder cancer, and reproductive disorders. Most of the associations are controversial. The balance of evidence, however, suggests to me that consumption at or above this level should be avoided.

More than 3% of North American adults consume in excess of 600 mg caffeine each day, i.e. more than 500,000 adults in Canada and more than 5,000,000 adults in the USA. Because drug abuse is most usefully defined as use to the extent that health is affected, I have little hesitation in regarding consumption above this level as abuse. Caffeine, by this reasoning, is a widely-abused drug.

Consumption of 600 mg caffeine can be achieved in a number of ways.

In North America, most caffeine is consumed in coffee, averaging about 80 mg/cup. Thus use of eight average cups a day will cause the 600 mg level to be exceeded. Cups of coffee vary enormously in caffeine content, depending on the kind of coffee used, the method of preparation, and the size of the cup. Cups made from instant coffee generally contain less caffeine than cups made from the ground bean. Percolation generally produces less caffeine per cup than drip and filter methods.

The enormous variation means that it may take as many as 20 and as few as four cups to exceed the 600 mg level. The variation in the caffeine content of cups of tea is even greater than for coffee and although the average value is lower — about 30 mg/cup in North America — there is considerable overlap. In the British Isles, where most caffeine is consumed in tea, it seems that the proportion of adults who abuse the drug is similar to that in North America.

In some countries, notably Belgium, Holland, and the four Scandinavian countries, caffeine use is much greater than in North America. The Swedes are the heaviest users. Their coffee consumption per head is more than twice that of people in the USA and more than three times that of Canadians. A majority of Swedish adults are probably dependent on caffeine.

There are three exceptions to the rule that health may not be in danger until daily use exceeds 600 mg caffeine. One exception concerns children and other light people. The effects of a given amount of a drug are usually greater among younger and among lighter people. There is no reason to believe that caffeine is an exception. A 9-year-old child who consumes three cans of cola and three small chocolate bars each day is probably using caffeine at a level equivalent to more than 600 mg/day for an average adult.

The second exception concerns pregnant women. Birth defects have resulted from caffeine administration to animals during pregnancy to the extent that, if a company were proposing caffeine as a new additive, it would not be approved. The risk is such that, according to the US Center for Science in the Public Interest, women in the first three months of pregnancy should use no more than the caffeine equivalent of one-tenth of a cup of coffee a day. (Use prior to conception might also be advised against. Caffeine is chemically very close to the constituents of the genetic code, close enough to interfere with reproduction. Animal studies have shown that feeding moderate amounts of caffeine to males for a month before mating can markedly increase the proportion of females in the resulting offspring. The University of Illinois has patented this procedure, which could be of great interest to stockbreeders. Whether men who drink a lot of coffee have more daughters than usual is not known.)

The third exception arises where other drugs are used. Caffeine has been shown to interact with many drugs, including alcohol, barbiturates, opiates, aspirin, paracetamol, isoniazid, L-dopa, and anti-anxiety drugs.

Thus effective dose levels of these drugs may vary with caffeine use. In some cases the toxicity of a drug may be potentiated by caffeine. Caffeine counteracts certain of the effects of insulin and may play a role in the regulation of this hormone, especially when consumed by diabetics.

Apart from these three exceptions, it should be stressed that use of moderate amounts of caffeine provides little cause for concern.

Richard Gilbert

Europeans face growing drug abuse...

By Thomas Land

GENEVA — West Europeans are facing a disturbing increase in drug abuse. Heroin addiction and cannabis abuse still persist while multiple abuse of psychotropic substances (barbiturates, LSD and amphetamines) is growing and involving users in ever younger age groups.

In Britain and West Germany, seizures of LSD are on the increase again. And in West Germany and France, burglaries of pharmacies are becoming frequent.

The United Nations' International Narcotics Control Board identifies Holland as the unchallenged centre of illicit supply and distribution of drugs in Western Europe, attracting large numbers of foreign consumers — mainly youth from North America and other parts of Europe. The board's report, issued in Geneva, shows traffickers supplying that market have changed some of their routes and methods of smuggling.

Before arriving in the Netherlands, cannabis of Moroccan origin tends now to come via France rather than Spain, and cannabis from the Middle East via Italy rather than the Balkans.

Heroin from south East Asia is arriving in increasing quantities in Holland, the board says. Carried by air, particularly from the Malaysian peninsula, it is transported to Amsterdam by car or train from a neighboring country in which couriers have landed.

"These individuals sometimes travel in groups in an attempt to evade the control measures," the report relates. "This method enables the traffickers to minimize the risks of interception, since customs controls have been reduced between the Benelux countries; also, the volume of road and rail traffic between the Netherlands and its neighbors makes it difficult to exercise systematic control — although control measures have been tightened up. It appears that heroin introduced into the Netherlands is, for the time being, mainly destined for the Western European market."

The government in Holland has taken various administrative measures aimed at strengthening the campaign against the illicit traffic. It has also asked Parliament to increase the penalties for traffickers while reducing those applicable to drug users. The board comments that regional action to help Holland is essential since the traffic increasingly affects several European countries.

Illicit suppliers, meanwhile, have taken to converting opium into morphine or heroin close to the areas of illegal or uncontrolled cultivation. It is possible, the board suggests, that traffickers are endeavouring not only to diminish the risks of interception by reducing the volume of goods to be transported, but also to diversify their sources of supply. Increasingly substantial seizures of brown heroin in Western Europe have thus clearly identified the use by the traffickers of an air route originating in Malaysia.

Large seizures of illicit cannabis consignments also support theories of a changing pattern in the trade.

...Common Market countries combine forces to combat illicit drug market and crime

GENEVA—A convention soon to be concluded is to bind the police forces of the nine European Common Market countries into a single cooperative structure to combat international crime.

It is certain to affect drug trafficking in Europe, where drug abuse is on the increase, as well as to provide a lead for law enforcement authorities of other countries.

Ministers of the Interior representing the nine countries are expected to meet in London late this spring to approve the convention. Britain, West Germany and France, the chief supporters of the scheme, consider the European Community is ready for cooperation against international crime on a scale beyond the bounds of Interpol.

Politically, the convention will answer the claim, made by many developing countries at a recent conference of the United Nations Commission on Narcotics in Geneva, that the industrialized nations are paying insufficient attention to the world trade in illicit drugs. It will provide a flexible framework for coordinated police activities and an immediate exchange of information and experience as well as personnel within the Community.

In the long term, it may well lead to the establishment of a federal European authority competent to deal with international crime involving several countries simultaneously.

Ministers attending the spring conference here will be essentially concerned with a different kind of international crime—terrorism, which was indeed financed from drug smuggling in many cases until the recent past. But narcotics specialists in the nine countries welcome the impending convention as a fine opportunity to bring their individual enforcement programs closer in accord.

Discussions leading to the convention have gone on for some time. The central figure to emerge in this latest stage of the negotiations is Roy Jenkins, the British Home Secretary, who has just visited M Poniatowski, his French opposite number in Paris, and who received a visit earlier this year in London from Herr Maihofer, his colleague in West Germany. The other Interior Ministers of the Nine are likely to lend unhesitant support.

Sources close to the British planners of the scheme explain the need to bypass Interpol in a continentwide search for permanent remedy to international crime in terms of the nature of that organization. It is well suited for the dissemination of information but not equipped to coordinate simultaneous international action. They point to a bilateral arrangement between the United States and France, bypassing Interpol, which has brought about spectacular success in the smashing of French smuggling organizations.

Western Europe established a full-time organization concerned with drug trafficking in a Ministerial meeting in Paris last year. The organization, involving permanent national representatives, is intended to promote a quick exchange of information while the new convention is to provide for centrally coordinated action.

In addition, the convention would enable the European Community to speak on international crime with a single voice and, perhaps more significantly, to link trade relations with good conduct in this increasingly sensitive sphere. If the scheme works, other groups of countries may well establish similar regional structures.

Driving after excessive drinking is common New Zealanders state in recent survey

AUCKLAND, N.Z.—More than 90% of New Zealanders believe that driving after drinking too much alcohol is common among this country's motorists, according to a Ministry of Transport survey of public attitudes.

Of the survey sample of 1,800 people, 56% claimed some or all of their friends drive after drinking too much; 25% admitted driving themselves after drinking to excess; and 70% said they did not mind having as a close friend someone who habitually drinks and drives.

Initial results of the survey appeared in a *New Zealand Medical Journal* article which observed that "in this country the social pressures to curb drinking and driving are not strong".

The authors, Dr A. G. Poynter and Mary Anderson, who run an alcoholism treatment unit, suggested persistent drunken driving offenders should be permanently deprived of their right to drive, no matter what hardship this causes.

For other offenders able to respond to treatment, they said restoration of a driving licence could be used as a method of constructive coercion to help motivate the offender to deal successfully with a drinking problem.

Around

. . .And not a drop to drink

Scotch could be rationed in Britain by the early 1980s according to a leading whisky producer. He is blaming "government ineptitude and greed which is starving the industry of the cash it needs in order to process enough liquor." The whisky industry in Britain produced about 200 million bottles less in the first 10 months of 1975 than in the same period in 1974.

Tough campaign

The British government has launched a tough anti-smoking campaign with strict licensing controls on the new synthetic tobaccos along with proposals for voluntary curbs on strong cigarettes. Nineteen million Britons — about half the adult population — smoke.

Liquor restraint

New Guinea recently celebrated Independence Day by banning all liquor sales for a week preceeding the holiday. Only tourists were exempt from the regulations which banned alcohol from taverns and made it an offence to consume alcohol in a public place.

Twist to open

The British Department of Health is planning to introduce regulations requiring pharmaceutical manufacturers and suppliers to package children's aspirin in child-resistant containers.

Mexican connection

The majority of heroin coming into the United States has been traced to Mexico where a study indicates that 90% of heroin confiscated in the US was processed in Mexico. In 1972, only 40% of street heroin was the "Mexican brown" variety, so called because of its impurities. For 1973 and 1974, the figures rose to 63% and 76%.

Affluence to blame

Rising affluence is to blame for the growing numbers of alcoholics in the world, according to the moral welfare committee of the Church of Scotland. In a report, the committee refers to alcoholism as "an unhappy dilemma which a prosperous society seems unable to face and unable to resolve". Other "unresolved dilemmas" the

Bulgaria renews efforts against alcohol abuse

By John Dornberg

MUNICH — Bulgaria has launched a major new anti-alcohol and anti-tobacco drive.

A joint decree by the Bulgarian State Council and the Bulgarian Communist party central committee in January, calls for "intensifying the struggle" against alcohol and tobacco abuse. It is the first such joint decree since 1958.

The document, which calls primarily for propaganda, links the drive against alcohol abuse and smoking to the ideological struggle. It alleges the practices of smoking and drinking "have their roots in the distant (i.e. the pre-Communist) past" and are "remnants of the bourgeois era".

Despite drastic increases in the price of alcoholic beverages three years ago, alcohol consumption in Bulgaria has continued to increase and according to the latest statistics is now almost twice as high as 1958 when the party and government last gave official attention to the problem.

According to the current Bulgarian Statistical Yearbook, which contains data through 1973, per capita alcohol consumption has increased from 7.6 to 13.5 liters annually since 1960. The number of people subjected to compulsory treatment in Sofia's sobering up stations increased from 8,000, when these were first established in 1961, to 26,200 last year.

Bulgarian media have stressed "a considerable proportion" of them were "young people".

Mladezh, the monthly of the Bulgarian Komsomol, the young communist league, ascribes the high alcohol consumption rate among Bulgarian youth to "mass advertising, the monotonous life of a great number of youngsters, disillusionment, and the imitation of Western fashions and life styles".

The new decree has more propagandistic than practical value. Paradoxically, it recommends measures that were introduced several years ago, such as a ban on advertising alcoholic beverages and tobacco products which was actually enacted by law in 1973.

It also urges the establishment of non-smoking and non-drinking rooms in certain cafes, restaurants, theatres and offices, though such rooms already exist. It demands an increase in the production of non-alcoholic beverages, though various government measures last year already dealt with the shortage of such drinks.

Two aspects of the latest decree, however, are new.

One recommends literary works on the subject be commissioned and drinking and smoking scenes not be shown on television and cinema screens.

Secondly, on the practical level, the document urges "severe public measures" (without specifying their nature) be taken against those who introduce minors to alcohol and tobacco. It also bans the sale of alcoholic beverages until after 12 noon daily. Up to now alcohol has been available in shops, cafes and restaurants from 9 am.

Finally, the new decree recommends "a more flexible price policy to curb alcohol and tobacco consumption". Sources here predict this presages another price increase — 50% in 1973 — which in practice, however, seems to have had little effect.

e World

committee listed were euthanasia, abortion, population control and public lotteries.

Sober February

The Finnish firm, Yhtyneet Paperiehtaat, has initiated "Sober February" where its employees pledge not to indulge in alcohol for the entire month. The scheme, which began last year in an attempt to curtail absenteeism and on-the-job accidents has expanded to other Finnish firms which are engaging in friendly competition with each other. During the first Sober February last year, accidents at Yhytneet Paperiehtaat fell by 28% but absenteeism remained about the same.

Luck O' the Irish

The cost of spirits in Ireland is rising as a result of a government attempt to gain increased revenue. Nevertheless consumption isn't decreasing as expected. Those who still indulge are now paying 10 cents more for a shot of whisky and a pint of beer.

Liver ails

France is at the top of the liver cirrhosis death league according to a recent survey which shows that country's rate of cirrhosis ailments at 40.4 cases per 100,000 of the population.

Swiss smokers

The 50-50 sharing of seats on the Swiss National Railway between smokers and non-smokers is to be altered in favor of passengers who don't use tobacco. The management says non-smokers will be allotted two-thirds of the space in all the new passenger cars on its long distance domestic line. The decision was made after 10,000 people were polled and 55% said they were non-smokers, compared with 30% who said they smoke and 15% who made no comment.

Britons may get longer pub hours if a proposed private member's bill passes third reading in the House of Commons. In addition to keeping pubs open between 10 am and 12 midnight each day, the bill would allow children in pubs before 8 pm — an attempt, says the bill's author, to introduce alcohol to young people in a family setting.

Longer pub hours?

Proposed bill would relax rules in UK

By Harvey McConnell

LONDON—A private member's bill that would loosen up the hours public houses may stay open in Britain has been given a second reading in the House of Commons despite strong reservations expressed by a Labour Government spokesman.

Conservative Kenneth Clarke's bill, which he describes as a "modest measure," would allow a pub manager to apply to the local magistrates to open outside the present prescribed hours, but within the limit of 10 am to midnight.

At present, pubs throughout the country cannot open before 11.30 am and must close by 3 pm at the latest and then open again from 5.30 pm to 11 pm depending on the area.

Mr Clarke's bill would also provide for the admission of children to pubs before 8 pm although the sale of any alcoholic beverage to them would be banned.

He told the House that any person with a drinking problem could obtain alcohol and abuse it without being inconvenienced by the present pub hours. The inconvenience of the present system was to social drinkers, tourists, and travellers.

Allowing children in would introduce them to alcohol in a family setting in restrained surroundings and stop it from being considered a secret adult thing.

Dr Shirley Summerskill, for the government, said the government would not actively oppose or support the measure.

But, she said, it was crucial for MPs to consider, in the present climate of increasing alcoholism, especially among the young, and of drunkenness and drunken driving offences, whether it was now appropriate to relax the present law on opening hours.

Opposition also came from Conservative Sir Bernard Braine, chairman of the National Council on Alcoholism.

He said drinking was a pleasant pastime for the majority. However, for a minority, it is a destroyer of health and happiness, a major factor in the breakdown of family life, and a potent cause of death and injury, he said.

Mr Clarke's bill still has many hurdles to overcome, including a third reading and then consideration by the House of Lords.

British anti-smoking lobbyists gain support

By Alan Massam

LONDON—Although Britons are still smoking 132,000 million cigarettes annually, there is a definite note of optimism creeping into the pronouncements of the anti-smoking lobby.

"One can go to parties these days and talk about anti-smoking without offending people," said dynamic Mike Daube, director of the Royal College of Physicians-sponsored ginger group, Action on Smoking and Health (ASH).

"In fact I find that talking about the dangers of smoking and the prospect the individual has for giving it up has become very definitely trendy."

Mr Daube was speaking after publication of the figures for tobacco sales during 1975 which showed that cigarette sales had declined by 3% in number and by 6% in weight (of tobacco).

The British budget for 1975 was declared on April 15 and cigarettes were still on sale at the old prices for some weeks afterwards. So the fall in sales due to price occurred in just over half the year.

Mr Daube believes the increased price of tobacco products has the effect of confirming the individual smoker's conviction that he should kick the habit. And, of course, the conviction itself builds up because the smoker is exposed to health propaganda.

The high point of cigarette tobacco consumption in the UK was 1960 when 239.2 million lbs weight was consumed. In 1970 the figure had dropped to 215.4; in 1971 it zoomed down to 204.1 (after the 2nd Royal College of Physicians report *Smoking and Health Now*); in 1972, 216.2; in 1973, 228.9; in 1974, 225.6; and in 1975, 212.6.

Mr Daube, who learned his campaigning techniques with the very energetic and successful housing ginger group, Shelter, believes this last significant drop in cigarette sales is particularly encouraging as it shows a number of factors are now positively influencing the smoker to give up the habit.

Among these he includes the efforts of Dr David Owen, Minister of State at the department of health and social security. Dr Owen is a non-smoker, committed to anti-smoking, and a shrewd politician.

"We are also very lucky in the officers we have working with ASH. They are all very competent and dedicated," said Mr Daube.

Recently, ASH set up an all party committee of Members of Parliament who support its aims and looks set to achieve a great deal in 1976.

British cigarette manufacturers agreed early in February to record on packets which tar group brand falls into. The tar groups are Low Tar; Low to Middle Tar; Middle Tar; Middle to High Tar; and High Tar, depending on how much tar and nicotine per cigarette is yielded in milligrams.

A statement from the department of health and social security said its objective was "to persuade those who cannot give up smoking to change to a brand of a lower tar group".

The department also published detailed information on the tar yields of 110 brands so that smokers could choose an alternative brand.

"There is evidence that progress is being made in reducing the tar yields of cigarettes smoked. The average tar yield per cigarette of all cigarettes smoked in July 1972 is estimated at 21.0 mgs. The corresponding estimate for June 1975 is 19.0 mgs," said a department spokesman.

New Zealand doctors claim blood-alcohol tests futile

AUCKLAND, NZ — New Zealand's blood-sample legislation for drinking drivers, criticized by doctors on ethical grounds when it was introduced three years ago, is under fire again — this time because it is not efficient enough.

Hospitals are required to take blood-alcohol samples from all drivers examined or treated after traffic accidents. But doctors and technicians complain they are wasting their time on the complicated sampling procedure because legal loopholes make conviction difficult to obtain.

At least eight millilitres of blood must be taken, without the use of an alcohol swab. The sample is divided into two portions, each of which must be sealed, labelled and signed, then held under refrigeration for 14 days while law enforcement authorities decide whether to prosecute.

Only a small proportion of samples is eventually used in evidence and Courts are dismissing an increasing number of cases on technicalities. After dissatisfied doctors at two of the country's largest hospitals decided to discontinue sampling, the government said it would convene an advisory committee to consider simpler procedures.

The blood-sampling legislation was enacted after studies showed excess consumption of alcohol was a factor in more than 50% of serious accidents on New Zealand roads. The legal maximum is 100 milligrams of alcohol per 100 millilitres of blood.

Fiji considers alcohol permits to cut crime

SUVA, FIJI—Personal permits to buy or drink alcohol have been recommended by a Royal Commission as a means of cutting the crime rate in Fiji.

Anyone found buying or drinking liquor without a permit would face imprisonment or a fine if the proposals of the Royal Commission on Crime are implemented. Those convicted for drunkenness would also lose their drinking permits for up to a year.

The commissioner, Chief Justice Clifford Grant, reported that the Fiji crime rate rose by 96% between 1970 and 1974. He said about 60% of prison inmates interviewed for his inquiry blamed alcohol for causing their crimes.

More Letters...

(continued from page 8)
these changes is modern technology, particularly in communications, with its apparent effect of depersonalization. It is understandable that many desire to escape into a romantic version of the past, or to dwell in the realms of the subconscious. But to do so is dangerous. I am profoundly distressed that the Addiction Research Foundation is choosing to encourage this foolish path.

André McNicoll
Ottawa
(Editor's note: The views of The Journal's editorial staff do not necessarily reflect the views of The Addiction Research Foundation.)

Musicians

Sir:
I was recently surprised to note in **The Journal**, (January) a rather detailed article by Harvey McConnell dealing with my relationship with various jazz musicians and the problem of excessive alcohol use. Although there are some inaccuracies, it is in general an interesting distillate of a talk I gave at the Annual Meeting of the National Council on Alcoholism, in Milwaukee, Wisconsin, last year.

Throughout the article there are a number of quotes which appear to have been taken either from a tape recording or from extremely detailed notes. I do not myself have a tape of this talk and I do not utilize notes. I am planning to repeat this topic this year in Washington, DC, and if you have access to an existing tape, I would be most interested in hearing it. Also, since the format of "The Back Page" of **The Journal** is so striking, I would like two or three copies for my personal use.

Again I must tell you of my appreciation for the interest you have shown in my work, and would like only to correct the erroneous concept that my long friendship with Edward Kennedy Ellington had anything to do with his drinking habits.

Thank you for whatever help you may be able to supply in my quest for an accurate and intelligible record of my own words which often come back to haunt me.

Luther A. Cloud, MD
Associate Vice President, and Associate Medical Director
Bureau of Employees' Health, The Equitable Life Assurance Society of the US
New York, N.Y.

LCBO

Sir:
The description of the 49th Annual Report of Liquor Control Board of Ontario in **The Journal** (March) was misleading and unhelpful.

The article was headlined "Ontario alcohol sales rose in 1975" and "Spiralling trend continues".

The intention behind this combination could have been no other than to suggest that Ontario residents are in the grip of an alcohol-beverage buying binge. The only information about sales given in the article, written by a member of your editorial staff, consisted of the statement that the dollar value of beverage sales was $683,258,454 during the year ending March 31, 1975, compared with $594,438,726 during the preceeding year. This suggestion of an annual rate of increase in sales of just under 11.5% would, by itself, indeed indicate a "spiralling trend".

The implication that alcohol consumption is rising at an alarming rate is quite wrong. The price of alcoholic beverages rose by an average of close to 7.5% between the two years. Moreover, the adult population of the province probably rose by close to 2.6% during the same period. Together these two increases mean that the dollar value of total sales could have risen by 10.3% without there being any increase in per capita alcohol consumption, leaving just 1.2% of the increase in the sales to be accounted for by increased use of alcohol.

The LCBO report itself gives some indication of how actual sales of alcohol changed between the two years. It can be found on the page following the presentation of dollar values. The increase in consumption, when corrected for the alcohol concentrations of the different beverages (40% for spirits, an average of 16% for wines and fortified wines, and 5% for beers), was 3.01%.

When the population increase is also allowed for, the true annual increase in per capita consumption is revealed to be 0.42%. This is a low rate of increase that certainly does not justify the scaremongering and alarmist headline that was used to highlight the article.

The rate of increase of 0.42% is unusually low when compared with the previous year's increase of 4.22% and the annual average for the previous five years of 3.60%. If this 5-year average rate of increase were to continue for 20 years, per capita alcohol consumption in Ontario would then be more than twice the current level and similar to what presently obtains in France, where half of all hospital beds are said to be occupied by sufferers from alcohol-related disease.

The very small increase in the most recent year may be a direct result of the general economic hardship. During the period 1930-1933, when there was an even greater decline in material well-being, per capita alcohol consumption fell by 40%.

Another unfortunate thing about the article is that it failed to note an important trend in beverage use that is featured in the Liquor Board's data. Per capita consumption of spirits was 5.68% higher during the year ending March 1975 than during the previous year. Wine consumption was 2.62% higher. Per capita beer consumption actually fell between the two years, by 3.74%. Beer continued to be the way in which most alcohol was sold.

But, if these trends continue into the current year, the residents of Ontario will be buying most of their alcohol in forms other than beer for the first time since 1933, the year before the legislation that opened hotel beverage rooms for the sale of beer and allowed the purchase of beer without a permit. (Because of the extraordinary amount of wine that is being made in Ontario homes, it is possible that most alcohol began again to be *consumed* in forms other than beer two or three years ago.)

The trend away from beer and, in particular, toward liquor is a trend that deserves far more attention than it has so far received. Although alcohol is alcohol however consumed, drinking patterns are the essence of alcohol abuse, and a fundamental change in pattern cannot but have implications for our understanding of the future direction of alcohol abuse in this province and elsewhere.

Richard Gilbert
Scientist
Addiction Research Foundation of Ontario
Toronto

Cannabis

Dr Eugene Le Blanc's speculations about the possible risks to society from cannabis use are indeed unfortunate because of their absence of substance and their genesis in extrapolative naivete.

The pharmacologist has failed to review adequately the wealth of historical epidemiological data extant in studies beginning with the 1893-94 Indian Hemp Drugs Commission or the vast amounts of clinical data in medical literature prior to the removal of this medicinal agent from the formulary.

Unfortunately, Dr LeBlanc's failure to do his basic historical research before uttering his statements render him a victim of bibliographic amnesia which then results in these prattlings that are devoid of scientific or social substance.

Besides reviewing the major studies such as the IHDC and the LaGuardia report, *The Opium Problem* by Terry and Pellens in 1929 should help to correct this defect in his perspective.

Tod H. Mikuriya, MD
Berkely, California

The Journal welcomes Letters to the Editor

Heroin use--'a national phenomenon'

(Continued from page 1)
ports on drug-related deaths, emergency room reports, hepatitis data, reports on price and purity levels of heroin, state and local law enforcement information, and drug abuse treatment admissions.

According to the indicators report, heroin-related deaths reported to the Drug Abuse Warning Network (DAWN), have gradually increased to 512 in the second quarter of 1975 from 363 in the three-month period from July to September 1973.

The data are based on reports from approximately 100 medical examiners in 24 major metropolitan areas and covering about one-third of the US population.

Heroin-related emergency room episodes reported to DAWN have shown a steady increase to 6,546 in the second quarter of 1975 from 4,248 in the last quarter of 1973.

These DAWN data are drawn from reports by more than 800 emergency rooms throughout the country.

Drug-related hepatitis cases have shown a dramatic increase from 1,436 in 1966 to a peak of 29,432 in 1972, levelling off at 22,775 in 1973 and remaining fairly constant since then.

The hepatitis data used in this report were based on Center for Disease Control reports. They relate primarily to serum hepatitis and those cases of infectious or unspecified hepatitis that may have been misclassified.

The national average retail price per milligram of heroin showed a relatively steady price increase from .95 cents in the second quarter of 1972, to a peak of $2.71 in the fourth quarter of 1974. Since then there have been two successive declines in the price, levelling out at $2.34 in the second quarter of 1975.

Over the same period, the purity of heroin has ranged from 9.8% in the second quarter of 1972, to a low of 6% in 1973, to a high of 12.3% in the second quarter of 1975. This involves unweighted national averages of both white heroin from Europe and Southeast Asia, and brown heroin from Mexico.

This is significant if one accepts the hypothesis that as heroin becomes more accessible its purity increases and price decreases.

The rate of arrests for heroin and cocaine made by local and state officials reached its peak in 1971 (74,000), dropped to 44,000 (pre-1969 levels) in 1973, and has since continued to rise (54,000) in 1974.

In terms of clients entering treatment, NIDA-funded programs show a relatively constant number between the second quarter of 1973 and the third quarter of 1974. There is then a 42% increase during the fourth quarter of 1974, with that new level maintained through to the end of 1975. This is roughly similar both in terms of new admissions and readmissions.

In commenting on the 18-month interruption in the "epidemic" in 1972 and 1973, Dr DuPont suggested the opium cultivation ban in Turkey, and the disruption of the French and European connections, were instrumental factors.

Since that time, however, the Mexican heroin trade has developed to the point it now accounts for almost 90% of the heroin entering the country.

"The point is heroin use has become a national phenomenon. It is no longer located only in large cities and particularly not in east coast cities," said Dr DuPont.

GM's absentee rate drops by half

(Continued from page 1)
dent claims had been filed by the 104 employees. One year after treatment, 99 claims were filed – a decrease of 46%.

● Absenteeism totalled 3,440 days one year before treatment for the same group of employees, but dropped to 1,779 days one year after treatment, a decrease of 48%.

● Sickness and accident benefits paid to employees also decreased by 48% one year after treatment, (to $48,691 from $93,554).

● Workmen's Compensation claims also decreased by 27% and the amount paid in benefits dropped to $3,981 from $11,078, a 64% decrease.

General Motors assembly line

The story differed considerably for the 48 employees who refused treatment, said Mr. Lunn.

Sickness and accident benefit claims increased by 19% one year after they were referred to the medical department by their supervisors. Days lost jumped to 1,521 from 688, an increase of 121% and the amount paid in sickness and accident benefits climbed to $43,413 from $19,102 one year before referral, an increase of 128%.

Some tragic incidents occurred in the lives of those 48 employees, Mr Lunn went on to say.

"We lost four through suicide; four more through cirrhosis of the liver at a very young age; and three in automobile accidents. We retired six or seven at an early age because they were no longer able to continue on their jobs, and six were fired."

Those remaining, Mr Lunn said, have since been referred again to the GM medical department and have gone for treatment.

Although treatment is not mandatory, those who refuse it and continue to deteriorate on the job are disciplined. Those who seek treatment are paid full insurance benefits. However, they too are disciplined if, after an appropriate period, efforts at rehabilitation have not worked, said Mr Lunn.

"Because we look at job performance, we feel it's the employee's responsibility to perform when he's at work. If his job performance starts to deteriorate, we feel then that it becomes our business to do something about whatever his problem is.

"We have the program, we have the policy, we feel we have good facilities in the treatment of alcoholism in this area, and we should use them," Mr Lunn concluded.

Plan to attend

ELEVENTH ANNUAL CONFERENCE OF THE CANADIAN FOUNDATION ON ALCOHOL AND DRUG DEPENDENCIES

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PLENARY SESSIONS

EPIDEMIOLOGY OF DRUG USE AND ITS CONSEQUENCES
Dr. Irving Rootman, Health and Welfare Canada

MEDICAL MANAGEMENT OF ALCOHOLICS AND DRUG DEPENDENT INDIVIDUALS
Dr. Albert Nantel, University of Laval, Quebec

PHARMACOTHERAPEUTIC APPROACHES IN ALCOHOL AND DRUG DEPENDENCE
Dr. Carl Pinsky, University of Manitoba

ALCOHOLISM AND OTHER DRUG DEPENDENCIES: A PRIVATE ILLNESS
Dr. George Strachan, Gillain Foundation, Victoria, B.C.

BEHAVIOURAL THERAPIES—OR PERSUADING PEOPLE TO BE DIFFERENT
Dr. Charles Aharan, The Victoria Life Enrichment Society, B.C.

SOME MODELS FOR THE PREVENTION OF ALCOHOLIC PROBLEMS
Dr. Wolfgang Schmidt, Addiction Research Foundation

CURRENT PROGRESS AND RESEARCH IN ALCOHOL AND DRUG EDUCATION
Dr. Michael Goodstadt, Addiction Research Foundation

DETOXICATION: ALTERNATIVES TO THE HANDLING OF PUBLIC INEBRIATES
Dr. Helen Annis, Addiction Research Foundation

INTERNATIONAL ASPECTS OF DRUG PROBLEMS
H. David Archibald, Executive Director, A.R.F.

SOME PERSPECTIVES ON DRINKING AND DRIVING
Ernie Pass, N.S. Registry of Motor Vehicles, Halifax, N.S.

IMPROVING THE REFERRAL SYSTEM: HOW TO GET THE CLIENT TO THE AGENCY
Dr. Peggy-Anne Brown, University of Alberta

SPECIAL INTEREST SESSIONS

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PRINCIPLES OF TREATMENT FOR WOMEN ALCOHOLICS
Doreen Brown, Donwood Institute, Toronto

PROFILE OF THE SPOUSE OF THE ALCOHOLIC
Manfred Winter and Edith Larson Calder Rehabilitation Center, Saskatoon

THE EXTENT OF THE ALCOHOL PROBLEM IN LABRADOR
Richard A. Boczkowski, Government of Newfoundation and Labrador

CHILDREN OF ALCOHOLIC PARENTS
Margaret H. Hindman, NCAI, Rockville, Md.

THE CHILD, ALCOHOL AND ABUSE
D. Frank Worrell, Alberta Alcohol and Drug Abuse Commission

COMMUNITY DETOXIFICATION SYSTEM—A SELF HELP MODEL
Bill Cline, Govt. of the Yukon Territory

DEVELOPMENT OF A TREATMENT MODEL FOR ALCOHOLICS
Dr. Z. Amit, Sir George Williams Faculty of Arts, Montreal

DISULFIRAM IMPLANTS FOR ALCOHOLISM
Dr. Allan Wilson, University of Manitoba

EVALUATION DU TOXICOMAINE EN CABINET DE PRATIQUE GENERALE
Dr. Michelle Cousineau, Medecin Conseil—Toxicomanies, Montreal

THE THOUGHT DISORDER OF THE CANNABIS SYNDROME
Dr. Alfred V. Milliman, Maryland Drug Abuse Research & Treatment Foundation

DEMONSTRATIONS

In lieu of field trips, representatives from treatment facilities in the province will demonstrate their methods at the conference.

A NETWORK OF COMMUNITY SERVICES FOR THE ALCOHOLIC
John Egan, Smith Centre, Thunder Bay
Bob Smith, Lawkin Centre, Thunder Bay

PINEWOOD CENTRE ALCOHOLISM PROGRAM
Dr. George Blake, Oshawa

OBJECTIVE SETTING AND COMMITMENT MONITORING WITH SKID ROW INEBRIATES: BON ACCORD'S BEHAVIOUR REVIEW GROUPS
Rev. D. F. Collier, Bon Accord, Elora

TEACHING COPING STRATEGIES TO PROBLEM DRINKERS: THE APPLICATION OF SELF-HELP STRATEGIES IN AN ALCOHOLIC HALFWAY HOUSE
Keith Walker, Spadina Project, Toronto

MAY STREET TREATMENT PROGRAM
Dr. E. Freedberg, A.R.F., Toronto

ADDICTION RESEARCH FOUNDATION CLINICAL INSTITUTE TREATMENT MODEL
Dr. Fred Glaser, Head of Psychiatry, A.R.F., Toronto

SYMPOSIA

FORMATIVE EVALUATION FOR PROGRAM DEVELOPMENT
Dr. Stephen L. Milstein
Institut National de la Recherche Scientifique-Sante Universite du Quebec, Montreal

BROAD SPECTRUM BEHAVIOURAL STRATEGIES WITH ALCOHOLICS
Dr. George Blake
Pinewood Centre of Oshawa General Hospital
Oshawa, Ontario

NARCOTICS AND ALCOHOL TREATMENT PROGRAMS IN MONTREAL AND VANCOUVER
Raymond D. Cohen
Director, Alternatives Program for Alcohol and Drug Dependencies
Vancouver, B.C.

ALCOHOL/DRUG ISSUES AFFECTING YOUTH
Gail Swainston
Toc Alpha
Alcohol and Drug Concerns
Toronto

SIMULTANEOUS TRANSLATION FACILITIES will be provided at all plenary sessions and at selected afternoon sessions.

AUDIOTAPES of all plenary sessions will be available at the conference.

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REGISTER TODAY. . .

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Conference fee: $60.00 if received prior to May 1, 1976
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Cancellation. In the event of cancellation of the completed registration, the Organization Committee will deduct 10% of the amount paid and will refund the balance

Cheque enclosed **Please invoice me**

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Your signature on this form indicates that you accept the conditions for Registration and the cancellation clause.

Coming Events

International Conference on Alcoholism and Drug Dependence — April 4-9, 1976, Liverpool, England. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

National Alcoholism Forum — April 9-13, 1976, Washington, D.C. Information: ICAA, Case Switzerland.

Treatable Aspects of Alcoholism — May 5-7, 1976, Thunder Bay, Sault Ste. Marie and Sudbury, Ontario. Information: Dr Hector Orrego, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, M5S 2S1.

National Nurses Society on Alcoholism Second Annual Meeting — May 6-7, 1976, Washington D.C. Information: Juanita Palmer, Chairwoman, Program Operations Committee, 2 Park Ave., Suite 1720, New York, New York, 10016.

Work in Progress in Alcoholism — 1976 — May 6-8, 1976, Washington, D.C. Information: National Council on Alcoholism, 2 Park Ave., New York, New York, 10016.

Alcohol and the Liver — May 14, 1976, Toronto, Ontario. Information: The Canadian Hepatic Foundation, Suite 1010, 65 Queen St. E., Toronto, Ontario, M5H 2M5.

22nd International Institute on the Prevention and Treatment of Alcoholism — June 7-12, 1976, Vigo, Spain. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

The Committee on Problems of Drug Dependence — June 7-9, 1976, Richmond, Virginia. Information Committee on Problems of Drug Dependence, NAS-NRC, 2101 Constitution Ave., NW, Washington, D.C. 20418.

Ninth Annual Eagleville Conference on Alcoholism and Drug Addiction — June 10-11, 1976, Eagleville, Pennsylvania. Information: Patricia Moretti, Conference Registrar, Eagleville, Pennsylvania, 19408.

Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies, INFORMACTION — June 20-25, 1976, Toronto, Ontario. Information: William Gilliland, Conference Manager, Addiction Research Foundation, 33 Russell St., Toronto, Ontario. M5S 2S1.

Rap Round-up 1976 — June 25-27, 1976, Swan Lake, New York. Meeting of recovered alcoholics who are working in the profession. Information: RAP, Box 95, Staten Island, New York, 10305.

In order to provide our readers with adequate notice of forthcoming meetings, please send announcements as early as possible to: The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

New Books

by RON HALL

The Seattle Public Inebriate Program:

A One-year Follow-up Study Of Client Outcomes
. . .by David L. Stallings and Gerald R. Oncken
Skid Road Community Council,
(107 Cherry Street, Seattle, WA 98104), 1975.
57p.

Using the "relative improvement index," the findings of this study reveal that treatment through different modes can bring about significant changes in alcohol addiction behavior and attitudes in Skid Row alcoholics.

Problems Of Drug Dependence 1975

. . .by the Committee on Problems of Drug Dependence.
National Academy of Sciences, (2101 Constitution Avenue, N.W., Washington, DC 20418), 1975.
1219p. $22.50

This volume contains the papers presented at the 37th Annual Scientific Meeting of the Committee on Problems of Drug Dependence. The 85 presentations are grouped under major headings including: sociology and epidemiology, clinical studies, clinical pharmacology, opiate receptors, treatment and rehabilitation, animal studies, and animal pharmacology; and range in content from reports of specific research projects in progress to the future of drug abuse research.

Behavior Modification for the Treatment of Alcoholism: An Annotated Bibliography

. . . compiled by C. E. Weise, S. Busse, H. Reed, and S. Price
Addiction Research Foundation,
(33 Russell Street, Toronto, Ontario. M5S 2S1), 1975. 287p.: $8.00

This fully indexed comprehensive bibliography contains citations and abstracts of 347 items dealing with classical and operant therapies used in the treatment of alcoholism and illicit drug addiction.

Other Books

Alcohol Intoxication and Withdrawal: Experimental Studies 11 — Gross, Milton M. (ed). Plenum Press, New York, 1975. Symposium held June 24-28, 1974 in Manchester, England. 667p. $43.15

Are You Driving Your Children To Drink — Moses, Donald A., and Burger, Robert E. Van Nostrand Reinhold Company, Toronto, 1975. 235p.

Positions Available

Le Patriarche:

A Santa Claus figure who helps addicts

By Lynn Payer

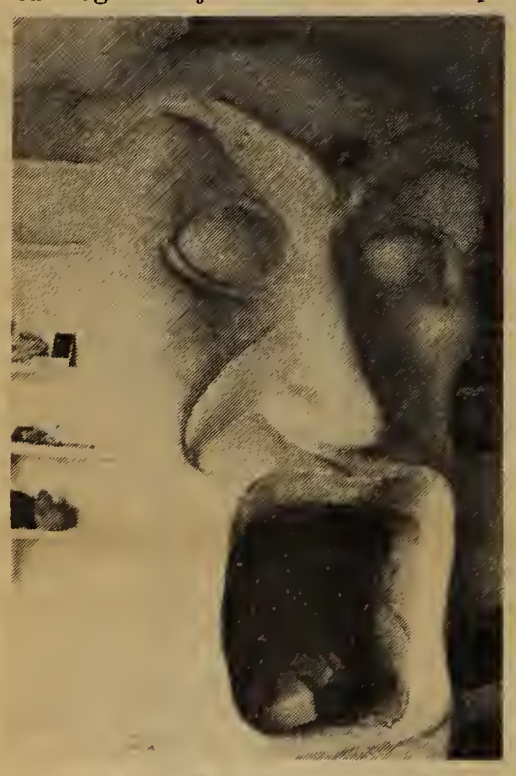
SAINT PAUL-SUR-SAVE, France—To call Lucien Engelmajer the *director* of the therapeutic community of La Boère is insufficient: His own designation as "Patriarch" is more descriptive.

For Engelmajer, a self-admitted megalomaniac who bears a striking physical resemblance to Santa Claus, not only directs La Boère, but founded it, supports it at least in part with his own money, and lives with his family in it.

It is Engelmajer's therapeutic concepts that are practised at La Boère; and it is his personality that makes life here a constant psychotherapy session. Engelmajer demands absolute cooperation from his professional, mostly part-time staff, and outlaws their keeping professional secrets pertaining to the community from him.

"If there were a priest at La Boère, he would tell the Patriarch what he heard in confession," explains Engelmajer.

While there may be theoretical or ideological objections to such an ap-



Extraordinary architecture right down to the trash receptacle.

proach, Engelmajer must be taken seriously on pragmatic grounds. He gets, and keeps, addicts off drugs and most re-enter society doing some form of useful work.

Engelmajer claims he has been able to do this for 70% of all the addicts who come or are sent to him: Of those who stay at least one month, the success rate is 80%. While there is no way to verify these figures short of hunting down ex-residents one by one, there is outside evidence that "Le Patriarche" has, in fact, been very successful.

Dr Claude Olievenstein of Paris's Marmotton Centre, and a World Health Organization consultant on addiction, says while he is uncertain of Engelmajer's figures, "he has had very good — extraordinary — results with very difficult cases. His results are perhaps better than elsewhere, and with very recalcitrant cases."

And when Le Patriarche, challenged at a recent addiction symposium in Paris about some of his methods, responded by counter-challenging anyone in the audience to name any of his "guys" or "girls" who had gone back to drugs after leaving the community, no one in the audience took up the challenge.

Le Patriarche

Engelmajer is not a psychiatrist. His interest in working with addicts seems to have evolved out of his interest in the counter-culture but his impatience with its freeloading ways.

When he met his second wife, Rena, more than 10 years ago, they decided to "live differently" as she puts it, and rented La Boère, an old farm.

Soon, the Engelmajers, with their interest in living off the land, in weaving, and in other arts and crafts, became a sort of nucleus that drew in young people interested in the same things.

Most of the young people, however, were interested in working only when they felt like it, and Engelmajer had no patience with them. Gradually, he began taking a larger role in dictating what was and what was not allowed his guests: Work was obligatory, drug use was outlawed. Little by little, La Boère began the transformation into a therapeutic community.

Work remains the basis of therapy at La Boère, although Engelmajer says it is "not just any work, but work that the addicts themselves want to do".

Although it is doubtful community members want to do *all* of the work they do at La Boère, most of the tasks are fairly routine ones such as farming and gardening. Members also help to repair and restore the old farm that forms the basis of La Boère and a "half-way-chateau" several miles away, and are given relatively free rein as to how they do this. As a result, the community and the chateau are veritable exhibitions of original art and architecture.

There are weavings, copper work, stained-bottle windows (in the chapel) and a home-made central heating system.

Besides the economic importance of the farm and gardenwork in making La Boere at least partly self-supporting, all work there has both a short- and a long-term therapeutic purpose.

In the long-term, it helps to provide community members with a vocation in life. Many of the residents who have left La Boère as "cures" have found employment either as artisans or as farm hands. At least two community residents with whom this reporter spoke claimed their stay at La Boère had shown them what they wanted to do in life.

Christophe and Thierry joined La Boère voluntarily—Christophe when he decided to stop taking drugs, and Thierry because a friend had convinced him it was paradise.

Christophe said the sophrology sessions (sophrology is a form of controlled relaxation, similar to yoga) convinced him he wanted to become a sophrologist: Thierry wanted to return to Paris and open an artist's studio, a desire, he said, that had only crystalized during his stay at the community.

The short-term purpose of work at La Boère is to keep addicts occupied during withdrawal. Most ex-addicts at La Boère who have previously undergone detoxification in French hospitals confirm the thoughts of Engelmajer on this matter: Addicts traffic drugs in hospitals because there is not much else for them to do.

"In general, too much attention is paid to the physiologic withdrawal, and not enough to the psychologic withdrawal," Engelmajer explains.

The community's schedule is therefore drawn up to leave little time for boredom. Everyone rises at 7 am for one hour of obligatory yoga, followed by one hour of garden work.

Breakfast at 9 am is followed by work restoring the old buildings and/or caring for the animals. Afternoons are free for rest or creativity.

Tasks such as cooking and dishwashing are rotated.

As for the physiologic withdrawal, addicts are given herb teas and acupuncture, and taken on long walks through the forest. Engelmajer recognizes that these are probably also for the psychologic withdrawal, with perhaps the exception of the long walks which are intended to tire the addicts so that they wil sleep well at night.

Once addicts arrive at La Boère, they receive no drugs and are given 48 hours to give up whatever drugs they may have with them. "After that, they risk their life," says the Patriarch darkly.

He is almost as intolerant of drugs prescribed by doctors to help the addicts through withdrawal. These are burned in the fireplace.

Two somewhat contradictory reasons are given for the "cold turkey" approach. On the one hand, Engelmajer claims suffering during withdrawal is a powerful conditioning that will make ex-addicts think twice before resuming drug abuse. On the other, he admits: "We tried using tranquillizers and other drugs and found they didn't ease withdrawal at all."

Engelmajer insists, in fact, that he prefers to take addicts who have not already undergone detoxification in a hospital—"It's easier."

Cigarettes are allowed and are quite common at La Boère, although Engelmajer himself has recently stopped smoking. Coffee drinking is allowed but discouraged: Every community member received as one of several Christmas presents a jar of decaffeinated coffee. "It was partly a joke and partly because most of them drink too much coffee and then can't sleep," explains Le Patriarche.

Marijuana, on the other hand, is strictly prohibited, the difference in policy between cigarettes and marijuana apparently being based on the fact tobacco is legal and marijuana is not. While Engelmajer feels rebellion against society is acceptable if it is creative, he does not feel that smoking a joint is creative rebellion.

However, he will go only so far in satisfying society's demands. The community is coed, and Le Patriarche believes forming a bond with a person of the opposite sex (or of the same sex, although he considers this less natural) is an important element in the therapy of an addict. Community members are therefore free to room with whomever they wish, regardless of sex, or alone if they wish. The practice has apparently shocked certain authorities. Engelmajer says he has been told: " Yes, we know, but can't you at least label the rooms 'girl' and 'boy'?" This he refused to do. "That would be the type of hypocrisy my guys and girls are trying to get away from," he says.

Perhaps the most striking feature of La Boère is the personality and availability of the Patriarch.

He lives with his wife and four young children in one of the buildings and residents freely enter and leave their living room. This trust plays a role in the therapy.

Marie-Elena, a 22-year-old with a 10-year history of heavy drinking and amphetamine abuse, tells how impressed she was when, on the night of her arrival, she was put to bed in the same room as the Engelmajer children because there was no other place for her.

Therapy is not limited to words: Le Patriarche tells, rather proudly, of the time he hit one of the female residents with enough force to break her tooth. He is insistent, however, that anyone who comes to visit La Boère ought to stay for several days "so that if you see me slap or kick someone, you'll understand the reason behind it".

Mellowing seems also to be characteristic of Le Patriarche. Community members don't refer to him as "Le Patriarche," but simply as Lucien. And, as my visit was at Christmastime, I witnessed little of the community's formidable work schedule: The dishes did get done and the cows got milked. But, Christmas Eve was celebrated with a dinner that included pate de foie gras, smoked salmon and oysters (donated by parents), and even a small amount of champagne. There were several presents for everyone, and dancing after the presents had been opened. Everyone slept late the next day.

As with most encounter groups, the people who stay tend to be enthusiastic about the place. Although one new arrival, a 17-year-old girl who had chosen La Boère rather than a psychiatric hospital, wasn't certain she could take it, other comments ranged from "I've learned a lot of things from Lucien," to "I came here thinking this would be like all the other treatment centres, but it isn't—you even begin to feel love here (from a young man with a seven-year history of heroin and amphetamine abuse).

La Boère is financed with money earned by Rena Engelmajer as an elementary school teacher, by Lucien's pension, and by contributions.

In a country where almost everything is state financed, La Boère receives a total of 53 francs (about $12) a day from the state because it is classified only as a lodging and not as a treatment centre. Engelmajer is trying to change this, but his unorthodox approach and lack of "credentials" are probably an even greater handicap in France than they would be in North America.

THE BACK PAGE

In fact, Engelmajer readily reels off a list of people who oppose him. (According to another addiction worker, Engelmajer tends to exaggerate his list of enemies.)

His outspoken views that doctors know practically nothing about drug addiction, and his disregard for the prescriptions that addicts bring with them to La Boère, have not made him popular with the medical profession.

The local community is not happy about having a therapeutic community nearby; the communists and socialists, says Engelmajer, are unhappy with him for having re-created the role of the father; and psychiatrists tell him that fixation on the Patriarch is just as bad as fixation on drugs.

"That's nonsense," he responds, "anything is better than fixation on drugs."

Probably the most fundamental criticism is that a therapy that so revolves around the personality of one man will have a hard time outlasting his personal dedication. The Patriarch admits he has no therapeutic tricks that can be easily transplanted.

When, for example, he was asked by the director of a less successful treatment centre just what was his gimmick, he answered: "You're looking for shortcuts. My wife, family, and I live in the community 24 hours a day, and I haven't taken a vacation for 10 years. That's part of the gimmick."

The welcome sign

Happier after their two-day battle and one small victory at the National Drug Abuse Conference, Martha Davis (centre) and her United Harlem Drug Fighters pose for The Journal. More from the conference on pages 4 and 5.

Harlem drug Davids take on NY Goliath

By Anne MacLennan

NEW YORK — A big, black and tough woman from Harlem put fire into the National Drug Abuse Conference.

Martha Davis came with her group, the United Harlem Drug Fighters, deploying them along meeting room walls of session after session to interrupt scheduled speakers.

The language was raw. The message: What's happening to people in the streets because of drugs.

By the second day of the conference there was talk, probably forgotten later, that the meeting would have to be stopped because of the interruptions.

The Davis tactics were to assault—not bodies but minds—with frightening reminders of an ugly, chaotic reality that might easily have been forgotten in the controlled conference atmosphere.

"People tell me I'm not sophisticated. You're damn right I'm not sophisticated. I haven't got time. Sophistication doesn't pay my bills. Sophistication doesn't service my people. I'm not dealing with sophisticated people. I'm dealing with socially deprived people.

"You're having a conference here and it's like a feast. You come to New York to see what it's all about but you not goin' to come close to no addict.

"But we've helped 15,000 people. We've detoxed people in 72 hours. We stay open 24 hours a day, seven days a week.

"You just learnin' a little about things we learned about a long time ago.

(See — Harlem — Page 4)

The Journal

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Ontario grappling with teenage drinkers

By Gary Seidler

TORONTO — The Province of Ontario is looking squarely at its teenage drinking problem in the wake of a government report commissioned by Premier William Davis.

The Youth and Alcohol Report, prepared over three months by Mississauga MPP Terry Jones on behalf of the Ontario Youth Secretariat, contains 32 recommendations to deal with what Mr Jones describes as a problem of "almost epidemic" proportions.

The wide-ranging report calls for some tough action, including raising the legal drinking age to 19 from 18, mandatory use of picture-identity cards for all those 25 years and under and stiffer penalties for drinking-driving offences.

Among other key recommendations are:-

● Liquor and beer producers should spend up to 20% of their advertising budgets pointing out the dangers of their products;

●Young people, adults, and operators of licensed premises who violate the age limit, should be handed substantial penalties;

●The government should raise the prices of alcoholic drinks to reduce abuse and help meet the escalating health and social costs of alcohol use and alcoholism;

●Young people between ages 16 and 18 should be given only probationary driving licences and face the immediate loss of driving privileges for one year for a first drinking-driving offence and two years for a second.

Most significantly, the government is urged to implement a "well-coordinated and clearly articulated beverage alcohol (control) policy".

Mr Jones pointed out liberalization of liquor laws in recent years has contributed to a significant increase in per capita consumption of alcohol, particularly among the 16-25 age group since lowering of the legal drinking age (to 18 from 21) in 1971.

"The situation has now developed to the extent where the 'real cost' of alcohol-related problems is of alarm-

(See — Report — Page 2)

Ontario teenagers favor the raising of the legal age limit and the requirement to carry a picture identification card, says MPP Terry Jones in his Youth and Alcohol Report. Above is a scene from Collision Course, a new ARF film on drinking and driving.

Gov't plans 3-way hit on alcohol

HARRISON HOT SPRINGS, BC—A national information program aimed at combatting alcohol abuse will begin this fall, says Health Minister Marc Lalonde.

The program is part of a three-pronged attack against alcoholism being launched by the federal government, Mr Lalonde told the 21st annual scientific meeting here of the British Columbia College of

(See — Canada — Page 7)

Detox system has little impact: ARF study

By Gary Seidler

LIVERPOOL, England—Ontario's multi-million dollar detoxification system is having little impact on the "revolving door" it was designed to replace, according to the first major evaluation of the much-heralded program adopted in 1971.

Moreover, the system which has created 13 detoxification centres (265 beds) and 17 halfway houses across the province, does not appear to affect drunkenness arrests in large cities, Dr Reginald Smart, associate research director of the Addiction Research Foundation of Ontario, told the Third International Conference on Alcohol and Drug Dependence here.

Dr Smart reported on several studies that he and Dr Helen Annis, ARF evaluation studies department, designed to determine the effects of the system on drunkenness arrests, the nature of the population served by the system, and the extent of rehabilitation provided for the systems' clients.

Prior to 1969, the typical revolving door situation (i.e. the cycle of intoxication, arrest, trial, short-term jail term, renewed intoxication) existed in Ontario.

Following a two-year trial with a *medically-managed* detoxification unit run by the ARF, the Ontario government committed $4.5 million over three years to develop a system of *non-medical* detoxification facilities and halfway houses which would operate as satellites of local hospitals. (The

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Inside

Heroin: Catastrophic global implications

See page 5

Report tackles pricing, age limit

(continued from Page 1)

ing proportions," the report notes.

"The rise in the aggregate social costs has made it evident that in Ontario, as in most other jurisdictions, there is no clear policy to give direction to the overall beverage alcohol system."

Further, the report recommends no further changes

Terry Jones

(which may be perceived as liberalization) be made as they relate to young people until and unless the consequences of these changes are known.

Mr Jones noted that Ontario's average per capita consumption has risen 30% since 1970 and this must be taken into account in assessing the increase in teenage drinking.

But he conceded that lowering of the drinking age in 1971 was a "big factor" in increased drinking among young people.

The report recommends government separate the legal drinking age from the 1971 age of majority package and raise it to 19 for a "significant" length of time to determine its effects.

Mr Jones said he is convinced this move would virtually remove legal drinking from the high schools.

He said only about 3% of secondary school students would be able to drinking legally if the age was raised to 19. This, Mr Jones contended, would result in less social pressure among students to use alcohol.

"There is little evidence to suggest this step would encourage under-age persons to use other drugs," Mr Jones added.

The freshman MPP, who spoke with about 25,000 young people, mostly in groups, around the province, found teenagers unanimously favored the raising of the legal age limit and the requirement to carry a picture-identity card.

Premier Davis said he would not comment on the report until each ministry affected by the recommendations had an opportunity to study the report in detail.

At the same time, Attorney General Roy McMurtry, who initiated much of the concern respecting mounting traffic accidents involving young peoples' drinking habits, indicated there should be full debate of the report and its recommendations in the Ontario Legislature.

The report tackles the controversial area of pricing as an effective means of control.

Convinced by research indicating that price is the single most significant factor in the average decision to buy or not to buy alcohol, the report recommends government seriously consider increasing the price of alcohol to a level that would significantly reduce abuse.

The price of alcoholic beverages should be pegged to the average disposable income, the report says.

Without even mentioning the "delicate" topic of exact price level, the report notes there is little consistency in the pricing of different varieties of alcoholic beverages and the price of pure alcohol in beer and wine is often nearly half that in liquor.

To counter the inconsistency, the report recommends price of alcoholic beverages be based on the concentration of alcohol present in those beverages.

In his travels, Mr Jones also found that people are concerned about the high cost of non-alcoholic beverages in licensed establishments.

Consequently, the report recommends the price of non-alcoholic beverages in licensed premises be no greater than one-third of the average price of a mixed drink. In addition, non-alcoholic beverages should be mandatory and their availability should be promoted.

The report falls short of recommending a ban on liquor and beer advertising, at least partly because Mr Jones is far from convinced there is substantial evidence to establish a relationship between alcohol advertising and the consumption and abuse of alcohol.

Mr Jones also says an outright ban on alcohol advertising would eliminate about 100,000 jobs.

However, the report does recommend that alcohol producers allocate sizeable portions, perhaps 20%, of their advertising budgets to portray the personally and socially harmful, costly, and undesirable aspects of alcohol consumption. They should include mention of the individual's responsibility and the positive alternatives to alcohol consumption and abuse.

The report also recommends that warnings of the possibly harmful effects be placed on each bottle of alcohol.

Rather than recommending a batch of new laws, the report simply urges that existing laws be more strictly enforced.

The report devotes comparatively little attention to problems associated with young peoples' drinking and driving habits although it does say:

"Perhaps the most distressing result attributed to the change in the legal drinking age is the phenomenal increase in the percentage of those between 16 and 19 involved in traffic collisions who were involved as drinking drivers."

The percentage of young drinking drivers rose from 6.9% in 1970 to 15.4% in 1973, a greater increase than for any other age group.

The report says a "major change of thinking" is required by all concerning the right of an individual to drive.

Subsequently, it suggests introduction of probationary rather than full licences for those between the legal drinking and driving ages (16-18 inclusive).

"Any offence committed against the drinking-driving laws should mean the immediate loss of driving privileges in addition to the sentences prescribed by the courts."

The report is critical of the education system for attaching a low priority to health education which "seems indicative of the social indifference to health problems, in general, and alcohol abuse, in particular, in spite of the immense cost incurred by the province each years as a result of such apathy".

Roy McMurtry

The report recommends the Ontario Ministry of Education place greater emphasis on alcohol education.

The ministry (education) should provide more extensive and adequate teacher training regarding both the content and processes of alcohol education and there should be a better developed and tested series of alcohol curriculum guidelines, the report continues.

Mr Jones, who acknowledges the assistance of the Addiction Research Foundation of Ontario with the development of various parts of the report, recommends the ARF be given the mandate to conduct research in several areas should his recommendations be adopted.

Of allegories and alligators and dead worms

By Wayne Howell

NOW MANY years ago there lived a chairman of a board of education who was especially vain about his anti-drug program upon which he lavished his personal care and attention.

He had sent away for fancy multi-colored posters saying "great oafs from little drinkers grow" and "a bad trip is no picnic".

He had sent away for plastic replicas of liquor bottles that said 'Cirrhosis' and 'Pancreatitis' on the labels. And he personally selected dynamic speakers that cursed the demon rum and maligned the malevolent weed. It was, thought the chairman, the finest drug program in the land.

But one day there arrived in the country two gentlemen who began to spread the story they had mastered the art of creating the most efficacious anti-drug program you could imagine. When the chairman heard this, he naturally granted them an audience.

"Mr Emperor," they said, addressing him directly, "perhaps you do not realize it but your program is too gross. Not subtle enough. Downright counterproductive."

The chairman, who took great pride in his program, was shocked. But he listened attentively because he wanted to have the best program in the land and if his were not the best, then there was always room for improvement.

"But this program is not about drugs . . . it is about carrots and radishes and beets . . . it is about vegetables," he said, after having examined the proffered materials.

"Only those who don't know an allegory from an alligator would say that," said the two gentlemen knowingly. "Only they would fail to see the subtle censoring of Mr Mushroom and his magical solutions."

"Oh . . .," said the chairman, who did not wish to be known as one who didn't know an allegory from an alligator. And so he presented the new improved educational package to the board of education with the proviso, of course, that only those who didn't know an allegory from an alligator would fail to see that this was an improvement on the primitive scare tactics of the past.

All the board members looked at the new program. And all could see the message. It was subliminal to be sure but they could see it. Which was very fortunate, because no one wanted to be known as a person who didn't know an allegory from an alligator.

And so the new program was introduced into the school system. The posters were junked and the dead worm in the gin bottle was put away. The chairman was very proud of his new program. Occasionally, only occasionally, a parent would come and query the chairman on the program but after the chairman explained how only those who couldn't tell an allegory from an alligator could fail to see this was a major step forward, all the parents without exception shook Mr Emperor's hand and said they did not see how they could ever repay him for his diligence and perspicuity.

But then one day there arrived two gentlemen from afar. They spread the story that they had mastered the art of creating the most effective anti-drug program ever. When the rumors reached the chairman, he naturally granted them an audience.

"Mr. Emperor," they said, "any vestige of negativism is counterproductive. You cannot inculcate positive values — the only defence against the scourge — with materials that even subtly hint at the old 'No! No!', an absolutely antediluvian concept."

They then showed the chairman their new improved educational materials.

"I have a healthy body, my body belongs to me," read the chairman, "and I can do just anything, just you wait and see." There were games and records, tapes and dances, kits and packages, all for a price.

"But this program contains no mention of drugs at all — not even a subliminated one!" exclaimed the chairman.

"Only the naive and the unsophisticated would say that," said the two gentlemen knowingly. "Only they would fail to see that even an allegorical allusion to drugs is the complete antithesis of what a modern 'positive' drug education program should be."

"Oh . . .," said the chairman, who did not wish to appear naive and unsophisticated. And so he presented the new package to the board with the proviso, of course, that only the naive and the unsophisticated would fail to see that this was an improvement on the allegorical approach. All the board members looked at the new program. They looked and looked. They looked and looked.

"It's an absolutely superb concept," they said at last, secure in their knowledge that although they as board members might have their faults, naivity was not one of them.

And so the chairman inaugurated his new program with great fanfare, convening a grand PTA meeting with board members, teachers, parents, and primary pupils in attendance. In honor of the occasion Chairman Emperor marched up the aisle, followed by the vice-chairman and the secretary of the board, singing "I have a healthy body, my body belongs to me. . . ." Everyone in the assembly cheered and applauded.

"My, my, will you look at the chairman's new drug program," they said as they examined the new teaching materials.

"Isn't it wonderful," some said.

"An absolutely positive step in pedagogy," said others.

No one dared let anyone else know he couldn't perceive anything at all for if he did the others would have thought him naive and unsophisticated or worse — a real dummy.

"But daddy," piped up a small child, "Mr Emperor has no drug program at all!"

This caused a brief commotion and people within earshot started to mutter among themselves; whispered conversations ensued.

"Don't mind him," said the boy's father apologetically. "He sniffs too much airplane glue."

The looks turned from ones of consternation to compassion. And a great cheer went up as Mr Emperor walked proudly to the podium.

(Wayne Howell is an Ottawa physician and freelance writer.)

Best site for wafer is behind ear

New stick-on wafer pill delivers right drug dose

By David Milne

PALO ALTO, Cal.—Scientists are developing a new system of administering drugs by means of wafers attached to the skin.

The stick-on wafers, now in the final stage of advanced clinical trials, are composed of four thin plastic membranes.

Under the top protective cover is the reservoir membrane which is impregnated with the drug.

Beneath that is the release membrane, a porous plastic through which the drug perfuses at a known steady rate.

The last membrane is an adhesive layer which sticks to the skin.

Although stick-on wafers that deliver scopolamine are currently being tested, other wafers are being developed to treat a variety of ailments, including high blood pressure, migraine headaches, asthma, and the menopause.

"The stick-on wafer is a far more efficient way of administering a drug than by the oral route," says Dr Jane Shaw, chief scientist at ALZA Corporation, developers of the controlled transdermal therapeutic system (TTS).

"It is very precise because it controls exactly the rate at which the drug enters the body."

It thus eliminates the initial overdose and later underdose of oral medications and avoids side effects.

Stick-on wafers produce a steady output of drug for 72 hours.

In tests, ALZA scientists found that the skin behind the ear is the best place to attach the wafers.

Dr Shaw believes the new system will replace many conventional pills because of its advantages and convenience.

Swallowing pills will become outdated, she says.

Dr Arnold Beckett, one of the world's leading pharmaceutical experts, acted as a consultant to ALZA during development of the stick-on wafer.

Said Dr Beckett, head of the department of pharmacy at London University: "With the stick-on wafer, you can produce the desired effect with a lower concentration of the drug, compared to a conventional pill.

"You can reach the site of the body where the drug is needed with less chemical change and side effects because it goes straight into the bloodstream.

"The stick-on wafer will be great for old people and children who might forget to take pills.

"It will also be good for people who can't—or don't like to—swallow pills."

In drug addiction treatment

Hypnosis 'rekindles self-respect'

By Tim Padmore

VANCOUVER—To the junkie, the pressures of life are like alligators—snapping at him from every side, dragging him down, drowing him. Confused and frightened, he strikes out for his familiar haven—a fix.

The alligator simile pleases Steve Dawydiak, hypnotist and passionate 'alligator hunter' for the Narcotics Addiction Service (NAS).

Gesturing, he drives off a phantom herd of the animals and explains how hypnotism can help a drug addict where other approaches have failed.

"What we are doing here, using hypnosis as a tool, is allowing human beings in stress to breathe freely, to collect their wits and take stock, without the alligators snapping at them."

Hypnosis, he says, allows him to rekindle a flame of self-respect in the addict.

"I hate this word 'junkie'. There never was such a thing as human junk and never will be, but these kids have begun to believe that they are junk," he said in a recent interview.

"Fundamentally they are beautiful people. Sometimes they are very stupid, very helpless, but they are also very sensitive, very talented.

"We try to show them that within themselves are all these magnificent qualities. We help the addict to see himself, not as he sees himself when he is in the midst of the alligators trying to stay alive, but as he really is."

Mr Dawydiak, assisted by psychologist Andrew Brottvick, has been treating addicts with hypnosis for the past seven months, and while the follow-up on the 37 clients treated so far is incomplete, there has been only one known relapse, which lasted only four days.

The hypnotist's presence dominates a room. A big, theatrical man with long, silver-streaked hair and a booming voice, Mr Dawydiak enters dressed in red-trimmed jeans and an embroidered and beribboned shirt from his native Ukraine.

He speaks at least six European languages and colorful English. Metaphor is his natural idiom:

"Madame Heroin is a very jealous whore: She gives you comfort, but eventually she's going to drop you—you need more and more of her and she does you less and less good.

"Methadone is changing one swine for another. You're just changing a whore for a pimp. You're paying with the same currency, not just money, but your freedom. You're in jail, your own personal jail, and the alligators are jumping on your back and drowning you."

Mr Dawydiak who, mercifully, insists on being called Steve, and who insists on calling his clients "friends", demonstrated his therapeutic technique with a 21-year-old addict whose drug career started at age 12 with speed (methamphetamine).

"I had a morning paper route, so speed seemed like a logical choice," said the addict during a pre-hypnosis interview.

To induce hypnosis the hypnotist used no gadgets, only a stream of poetic sleep images.

Once the subject was in a deep trance, Mr Dawydiak reinforced the idea that the addict was gaining control of his life.

"You know how to tackle the hassles . . . you are finding that the people who hassled you have beauty too . . . you are winning the battles and soon you are winning the war . . . we march beside you and sometimes you will get tired and we will help you and you will march on again."

Mr Dawydiak, whose formal training is as a psychiatric nurse, said he sometimes uses special hypnotic techniques, such as regression and memory recall, but added:

"We are not going to try to pump out something our friend doesn't want to tell us. Who are we to march with our dirty boots into that place?"

The demonstration session, the addict's third, lasted an hour, but some have lasted five hours or more. Typically, eight sessions, spread over two months, are scheduled at the client's convenience, even when that means working late at night, said Mr Brottvick.

Mr Dawydiak said hypnotism has been little used in treating drug addiction and described his own approach as unique.

He complained about the limited support given his program by the NAS, which is facing the possibility of budget cuts this year.

Mr Dawydiak, who has a couch (it was donated by NAS executive director John Russell), said he needs a bigger office and would like support for a research study which would be headed by two Vancouver psychologists who have been working informally with the program.

Decriminalize heroin: U S official

By Saul Abel

LOS ANGELES—A top California State official believes the use of heroin should be decriminalized nation-wide.

Dr Jerome Lackner, director of the California department of health, told a state assembly subcommittee he favors removal of penalties only for use of heroin, not its sale.

Under a bill enacted six months ago, one of the most severe in the nation, prison terms are mandatory for convicted heroin sellers.

Prior to passage of the law, judges had discretionary power to sentence sellers to prison or to place them on probation or in drug rehabilitation programs.

Now, anyone convicted of selling or offering to sell a half-ounce or more of a substance containing heroin must be sentenced to a prison term ranging from five years to life, depending on the individual's previous record.

Decriminalization of heroin use is necessary to take the profit out of heroin dealing, Dr Lackner said. He prefers government heroin clinics to government methadone clinics because methadone may be more permanently addictive, he said.

Pro-methadone groups in California have felt the position of the state is to limit, if not eliminate, methadone as a treatment method.

In an interview with **The Journal**, N. T. Schramm, president of the California Conference of Methadone Programs, said his group "does not advocate methadone maintenance as a panacea, but believes it is a viable treatment modality and in some cases the treatment of choice".

California regulations on dispensing methadone are much more stringent than federal regulations in regard to patient selection criteria, staffing, take-home requirements, and operating hours, and may be "counterproductive to treatment," Mr Schramm noted.

The California Conference of Methadone Programs has recommended the state set up a special panel to review and modify these regulations.

Dr Richard Koch, deputy director of the community services division in the department of health, told **The Journal** the number of state-approved methadone maintenance programs in California has remained fairly stable at about 60 over the past year.

The level of state funding also has been relatively constant, he said, accounting for about one-third of the more than $15 million for support of methadone treatment.

"We see long-term methadone maintenance as a viable addiction treatment for some patients but certainly not all," Dr Koch said. "We expect the number of approved methadone maintenance slots to remain at approximately 8,500, and the number of filled slots to remain at about 6,500.

"We anticipate increased emphasis on outpatient methadone detoxification, with substantial expansion of the present number of 365 approved slots."

Short-term detoxification has a fiscal advantage in that it has the capacity to treat about 36 addicts per funded slot per year, he explained, and detoxification is available to all addicts 18 years of age or more, while maintenance requires more restrictive patient selection criteria.

Dr Lackner emphasized his views on decriminalization of heroin use were strictly his own, and not necessarily those of the governor or the state. Later, Governor Brown said he favored retaining criminal sanctions against the use or possession of heroin.

A recent report by Dr Forrest S. Tennant, professor of public health at the University of California at Los Angeles, placed the number of heroin addicts in Los Angeles County at between 30,000 and 60,000.

Heroin abuse in the county is 10 to 15 times greater than it was 15 years ago, he estimated. Though heroin abuse appears to have stabilized recently, such periods in the past have always been followed by upward trends, he pointed out.

Another pertinent report, by the General Accounting Office in the nation's capital, has indicated that diversion and abuse of methadone was responsible for more than 1,600 deaths throughout the country in 1974 and 1975, reflecting a need for stricter enforcement of regulations.

The decriminalization of heroin, and the establishment of government-run heroin clinics, has been suggested by a California State official as one way to take the profit out of heroin dealing in the US.

National Drug Abuse

Harlem fighters win a minor victory

(continued from page 1)

"We have to focus attention on the problem we got now. We got no money.

"Grass roots programs cannot get their money. They have no political force. You ask us why we rise up. What do we do? Hit the streets? The cops would bust our heads.

"We gonna raise more hell and somebody gonna listen."

Somebody did listen to Martha but it was the third day of the conference before any but a few knew it. In the meantime, other voices often from worlds very different from Martha's talked, in their way, about what lack of money for treatment could do to the quality of life—not just in Harlem or New York City but in the nation, perhaps nations.

With a battery of facts and figures and statistics to back them up, they projected, in New York alone, a $74 million loss in revenue for local drug treatment programs.

The projections were based on New York State cutbacks of $18.6 million, proposed city budget cuts, and a direct loss of federal matching funds.

About 25 or 30 methadone maintenance clinics and 60 to 70 drug free agencies will be forced to close their doors, said Dr Bernard Bihari, director of the city's Methadone Maintenance Treatment Program and assistant commissioner of health.

That will force about 16,000 patients out of treatment and almost all of them, he said, will return to heroin use.

There will be incalculable social consequences—an increase in burglary, muggings, armed robberies and other drug-related crimes in the city.

It will have an immediate impact on the quality of life in New York City and consequently the nation, Dr Bihari said.

'Martha'

Dr Joyce Lowinson, conference chairperson, psychiatrist, and chief of drug abuse programs at Albert Einstein College of Medicine, spent much of the conference time warding off trouble, breaking up arguments, putting meetings back together again after they had been torn apart by demonstrators.

Now, she said: "A fast and recent national increase of heroin availability and use is over-widening the spread between committed federal dollars and the number of people in need of drug treatment programs."

In New York City, four ambulatory detoxification clinics have had a 21% increase in admissions in the past year to 401 a month in January and February of 1976 from 329 a month in the first two months of 1975, she said.

At the same time, the Drug Enforcement Administration of the US justice department has reported a sharp increase in the amount of yellow-brown heroin smuggled across the Mexican-American border.

"The sharp resurgence of heroin use will increase the pressure on treatment facilities at a time when they are being closed on a massive scale."

Martha Davis and her fighters weren't alone in their dissatisfaction with the relatively restrained tone of these official speakers. Other black and Puerto Rican grass roots workers with years of experience "getting our hands dirty" also shouted their desperations.

They didn't want establishment politicians—outsiders—telling them how to deal with their own people. They needed money and, incidentally, jobs. They did not need more training. They knew the pain. They knew the streets. They knew what to do or felt they did.

No one had answers for any of them but the conference survived. And for Martha Davis at least, there was a partial answer.

On Sunday, the third day, Dr Beny Primm, executive director of the also-threatened Addiction Research and Treatment Corporation of New York, "the largest black-directed non-profit methadone maintenance corporation in America," turned his own speaking time over to Mrs. Davis.

She explained that her program at Harlem Hospital is funded by the National Institute of Drug Abuse and that last autumn the funds had got clogged somewhere in the long bureaucratic pipeline that leads down from one of the richest agencies in the land into the dirty, troubled streets of Harlem. Her program had been unable to pay its bills since October and was desperate.

"Now," she said, "we've got our money—$160,000." In the hours since Friday morning, the United Harlem Drug Fighters had won a small victory. They had got some of the money owed them.

In some strange schizophrenic shift of loyalties, the formerly jeering crowd now stood and applauded Mrs Davis.

"Many of you that's clapping now are the people that was calling us hoodlums on Friday," Mrs. Davis reminded them.

The money—and only the bitter would call it blackmail money—will only pay for the past and not even all of the past... only until February. For the rest of the time and for the future, Mrs. Davis, like many other treatment workers, will simply have to hope the money will come.

Outside the room where Mrs Davis was speaking, in the plastic and cavernous lobbies of the large hotel which is testimony to society's hunger for vast conferences on human problems, were small roving groups of children talking to anyone who would stop and listen.

They too were black, white, Puerto Rican—and from an area of the city which, some would say, has already doomed them. They needed money for youth programs—summer camps, playgrounds, crafts.

They are not addicts yet.

Hiring climate may be improving for ex-addicts

HELPING THE ex-addict get a permanent job has often been one of the most frustrating aspects of rehabilitation.

But a recent study of business and industry in New York State gives some indication that attitudes to hiring ex-addicts may be changing for the better.

Dr Louis Lieberman of the City University of New York emphasized that the larger the corporation, the more likely it is to have ex-addicts on staff, and the more likely it is to hire ex-addicts in the future.

He also revealed that if a firm has a medical officer actively involved in the hiring process or readily available to management, the chances increase that a qualified ex-addict will be hired.

Dr Robert DuPont, NIDA chief, presents Dr Joyce Lowinson, chairperson of the conference, with a plaque commemorating the event.

The study, which involved interviews with executives, management, and medical officers in 113 New York State corporations, was part of a larger survey of drug abuse within industry in the state. The study was sponsored by the National Institute on Drug Abuse.

The on-site work force of firms in the sample amounted to almost 280,000 employees.

Dr Lieberman said hospitals, banks, and the utilities were most likely to hire ex-addicts, while mass-media, insurance, construction, securities, airlines, trucking, garment, and maritime firms were the least likely.

He reported that 45% of the firms sampled employed ex-addicts, and an additional 35% said they would if the right person applied. Only 13% stated they would not hire such a person. Seven percent would not answer the question.

Of the 23 firms sampled with more than 5,000 workers on the payroll, 91% claimed to employ ex-addicts, while 19% of the firms with fewer than 500 workers employed ex-addicts.

Large firms tend to have company physicians, and this appears to be a critical factor in changing the attitudes of management, said Dr Lieberman.

Even where there is a part-time physician present there is a greater likelihood of employment of ex-addicts.

The report reveals that almost three quarters of the firms with a physician on duty employ ex-addicts, while only 21% of those without medical officers employ ex-addicts.

In some cases these physicians have been instrumental in changing the minds of management to look upon ex-addicts more favorably, according to Dr Lieberman. In still other cases, management felt more confident about the prospects for an ex-addict after he had gone through a pre-employment examination.

The New York survey also showed that resistance to hiring an ex-addict was often influenced by a complex set of discriminatory attitudes.

For example, those who were reluctant to employ blacks, Hispanics, and women, were also more reluctant to hire ex-addicts. Of the firms with small percentages of blacks and Hispanics (less than 10%), only 17% claimed employment of ex-addicts. At the same time, 69% of firms with a majority of workers drawn from these minority groups claimed they currently employed ex-addicts.

Similarly, a quarter of the firms with 10% or fewer women in the work force employed ex-addicts, while 63% of the companies with a majority of female workers have ex-addicts on their staff.

"It appears that reluctance to hire the ex-addict may form part of a larger pattern of discrimination in which the addict is stereotypically seen as black or Hispanic," said Dr Lieberman.

"Certainly, the links between racist and sexist attitudes should not surprise us."

In general, management personnel who have hired ex-addicts seem satisfied with their job performance.

Among the firms where management could offer an assessment of the ex-addict's capability, two thirds said ex-addicts were good workers, possibly better than others on the payroll.

Similarly, two thirds of management personnel said the turnover rate of ex-addicts was the same or lower than of non-addicted workers.

Dr Lieberman, who is with the Graduate School and University Center of CUNY, is also adjunct associate professor, John Jay College of Criminal Justice.

Conference 1976: Anne MacLennan and Milan Korcok report from New York

Drug Abuse Council consultant Dr Peter Bourne says the relentless spread of heroin addiction poses a serious threat to all countries.

Doctors shy of own problem

THE PHYSICIAN with alcoholism may not know enough about the disease to know he's got the problem, says Dr Kenneth Williams, University of Pittsburg school of medicine.

This is despite the fact that studies suggest doctors are a very high risk population and that the incidence of alcoholism among physicians is estimated to be 12 to 20 times greater than in the general population.

One study, said Dr Williams, suggests half of all the time physicians spend in hospitals as patients is the result of self-medication with alcohol and other drugs.

They know the treatment of consequences and of withdrawal but not how to diagnose or how to treat the problem, he said.

"I had absolutely no training on how to diagnose alcoholism and what to do about it.

"There is also a feeling of why make a diagnosis if there is nothing you can do about it anyway. I feel there's a lot a doctor can do."

He referred to studies suggesting the way physicians are selected for medical school may encourage development of alcoholism because it leads to "tremendous problems" of role strain. Doctors are supposed to have an all-together facade, he said. This presents treatment problems.

Another factor is that it is difficult to reach the prestigious position of physician and once it is reached, there are few people who have any authority over a physician's personal and professional habits.

Additionally, physicians handle their own cases by prescribing for themselves, he said.

There is also a tremendous reluctance to associate alcoholism with physicians — this is true not only of the general public but of physicians themselves, he said.

Heroin: Catastrophic implications

All nations are threatened

By Milan Korcok

THE RELENTLESS spread of heroin addiction into Latin America, Africa, Europe, and Asia, poses a serious threat to the future of many small as well as established nations, says Dr Peter Bourne, consultant to the Drug Abuse Council.

Speaking to the third annual National Drug Abuse Conference, Dr Bourne emphasized such trends hold "catastrophic implications" for the world as a whole.

"We need in the United States, to begin to see the problem as one which must be dealt with on a worldwide basis—not merely as an effort to keep heroin out of this country."

There is a certain futility in trying to deal with heroin on a purely national basis said Dr Bourne, who suggested such unilateral efforts often make a bad situation worse.

For example, there is evidence international efforts to interdict the flow of heroin to the US have contributed substantially to a "worldwide heroin epidemic" simply by the process of their deflection, suggested Dr Bourne.

When US troops pulled out of Southeast Asia, a very lucrative market evaporated. But it was not long before traffickers, looking for alternative buyers, turned to the indigenous populations of young, urban, often alienated males. The result? Thailand now has an estimated 600,000 heroin addicts, up from 300,000 only three or four years ago.

In Burma, a similar problem exists. One physician in Mandalay estimates 3% of college students in that city are heroin addicts.

In Malaysia and Indonesia heroin use has also climbed dramatically in the last three years.

There is a belief among some authorities, said Dr Bourne, that the intensive US efforts to get Thailand and Laos to pass laws suppressing traditional opium use have simply encouraged a shift to heroin, which is colorless and more easily concealed. This in turn has triggered widespread use of this drug not only among the older opium users, but among young people who did not previously use drugs.

There also appears to be a serious situation developing in Afghanistan and Pakistan which might prove of great significance in terms of future international trafficking trends.

This area has long produced large quantities of opium said Dr Bourne, but most of this has been consumed locally or in neighboring Iran. However, this appears to be changing and last year, for the first time, a heroin processing laboratory was found in Pakistan.

Nationals of both Afghanistan and Pakistan are suddenly becoming aware of the immense potential source of wealth in their otherwise poverty-stricken countries.

This may pose a threat not only as a new source for markets in the United States and Europe, but also for the largely unexploited potential in Africa and certain parts of the Middle East.

In Iran, long an opium-consuming country, large quantities of heroin have begun to appear, particularly among young people in urban areas. There is little evidence, said Dr Bourne, that the Iranian government is taking steps to control this use, and at present it is estimated that there are 300,000 opium and heroin addicts in that country.

In Europe, there appears to have been a significant increase in heroin use, particularly in Germany, Italy, Denmark, and the Netherlands, said Dr Bourne.

He suggested that should the renewal of Turkish opium cultivation lead to a resurgence of heroin trade from that quarter, European countries would provide a prime and affluent market that would be far easier and less risky to service than the United States.

In respect to United States heroin traffic, the Mexican connection is clearly taking on new dimensions. In 1972, heroin coming from Mexico represented only 20% of all heroin consumed in the US. By 1975 it amounted to more than 90%.

Dr Bourne estimates that in the last 12 months, seven tons of heroin produced in Mexico (with a border value of $315 million) have come into the United States.

At these levels, the heroin trade amounts to 6% of the gross national product of Mexico, and is the number two foreign currency earner, next only to tourism.

So far, few Mexicans have become addicts. But should the United States be successful in interrupting the flow of heroin into this country, traffickers would simply divert their energies to setting up markets in Mexico and Latin America.

He says when a heroin market dries up, either through interdiction processes or various diplomatic pressure devices, growers do not stop growing opium, they just look more aggressively for new markets. Apparently, they are not hard to find.

There still remain large areas of the world which are highly vulnerable to the spread of addiction, said Dr Bourne. In Africa and South America, social change, urbanization, and growing alienation of young people has created an ideal situation for spread of this problem.

The immense financial profits that are part of the heroin trade also offer a persistent lure to a great many people. This not only corrupts, but builds into national institutions a vested interest for not interfering with the cultivation or trafficking of drugs. In poor countries, this could lead to serious undermining of the national economy, he said.

In seeking to restrain the spread of addiction, Dr Bourne recommended the United States deal with the problem on a global basis. It is not enough just to keep heroin out of this country, he said.

"We must help other nations develop the expertise to deal with their own addiction problems with a far greater level of commitment than we are making at present."

He suggested development of a well-funded assistance program to help various countries confront the problems of drug addiction. And he further suggested such programs be linked to economic development in those countries so that heroin is no longer seen as a major source of national income.

Addiction is now a global, not exclusively an American problem, said Dr Bourne. "We can no longer afford to blame other nations for the drug problems that have developed in the United States."

Drug histories crucial in aged

THE ELDERLY have "some remarkably inaccurate and distorted information" about drug use, says Dr Milton Burglass of the Drug Problems Resource Center, Cambridge, Mass.

It is not that old people are being told lies, Dr Burglass told a session on substance use in high risk populations.

Rather it is that they hear what they want to hear at a time of life when they are particularly concerned with their bodies and drugs are a very common topic of conversation.

"It's amazing to me what they don't know about the substances they are taking," said Dr Burglass.

He suggested physicians especially should consider much more seriously the importance of careful drug histories of patients. They should not simply note the types of psychoactive drugs patients are taking but also explore the dynamics.

"Much of what we glibly attribute to getting old is at least in part a function of psychological attitude," he said. He suggested, on the basis of his study, that drug abuse in the elderly is adaptive behaviour—an attempt to try to cope with something in a new way—not regressive.

Physicians, however, do not have to bear total responsibility for the situation. In his study of 23 elderly drug abusers, 15 had got the idea of taking the drug from a friend or member of the family.

Seven had been given the idea by their doctors but only in one case was the suggestion inappropriate.

The drugs were supplied in 10 of 23 cases by friends, in eight cases by pharmacies without prescriptions, and in five cases by physicians.

Dr Burglass's study involved 23 elderly drug abusers found among 483 geriatric patients—130 consecutive admissions to chronic care hospital; 300 consecutive admissions to geriatric outpatient clinics; and 53 psychiatric consultations. The 23 represented 4.8% of a total of 483—13 were female and 10 male, about the same ratio sex ratio as in the total number of 483.

The most frequently used group of substances, not surprisingly, was the minor tranquillizers. Three patients were using analgesics, three or four were using stimulants; one, antidepressants; two, sedatives; and two, major tranquillizers. Three were using other drugs. None of the 23 was involved in drug experimentation.

Individual problems surfaced in three main ways. Eight people presented with clearcut withdrawal; eight with symptoms of advanced intoxication; and four with side effects. The rest were self-referrals.

In 18 of 23 cases there was a clear precipitant in the environment which immediately preceded drug use. Five of the 23 had "fuzzy" histories.

Profile of David Pittman

His work is part of the addictions language

By Harvey McConnell

ST. LOUIS, Mo. — The value of the huckster approach has never been lost on Dr David Pittman, PhD. He has resorted to it often with remarkable success: Two of his efforts in the addictions field are now part of the language.

The first came from his study of treatment, or lack of it, for the chronic drunkenness offender. He thought long and hard about a snappy title for his monograph before settling on *The Revolving Door.*

A decade or so later, following a visit to Poland and a close look at sobering-up centres in Warsaw, Dr Pittman returned to St Louis and persuaded the city to set up North America's first (his words again) detoxification centre.

"It is gramatically incorrect: It should be detoxication," Dr Pittman agrees. "But to give it a little more punch we decided to use detoxification.

"Anyway, I don't give a damn if it is gramatically incorrect, because language only lives if it creates new words."

Dr Pittman is no stranger to old words either and uses them with telling effect. A leader in the campaign to get the public drunkenness offence decriminalized, he is equally outspoken in lashing Congressional parsimony in providing funds for alcoholism research.

Nor is he afraid to take on fellow academics, as is illustrated in his frank criticism of those who think they have developed a program of controlled drinking for alcoholics.

Dr Pittman combines his work as director of the Social Science Institute at Washington University, St. Louis, with travel and research. This has varied from trying to find the elusive "stabilized" heroin addicts said to exist in Britain during the 60s (if they are about he didn't find them), to observing recently the drinking patterns of Germans who have lived for several generations in South America.

Alcohol and its associated problems are more than just a research interest for Dr Pittman.

"It would be easy to say I got interested in alcoholism because my father was an alcoholic and my brother is an alcoholic, although that is not strictly true," he said.

A native of Rocky Mount, North Carolina, where tobacco is king, Dr Pittman eschewed a family preference for law or medicine when he entered the University of North Carolina. He opted for sociology and the budding study of Southern "social problems" which translated to "race problems".

A three-year spell in the Air Force at the end of World War II was followed by graduate work at Columbia University and then the University of Rochester, New York where he first studied the problems of the alcoholics in jails and penitentiaries.

Work on a doctorate at the University of Chicago produced *The Revolving Door!* "It is a term I do not get tired of hearing. Everyone has an ego."

In 1958, Dr Pittman moved to Washington University. Although not medically qualified, he is well versed in the science of medicine and teaches both medical students and psychiatric residents.

In the early 1960s Dr Pittman was appointed a sociologist attached to the St Louis police department. He found the lawmen there "as appalled as most police officers are as to what to do with the chronic drunk offender".

His visit to Poland in 1962 to attend an international conference on alcoholism provided the eventual answer.

Dr Pittman recalls his first sight of Warsaw's sobering-up stations: "They were old army barracks along the shores of the Vistula River. There the public drunkenness case was brought in from the streets, given a medical examination, a vitamin shot, and then put to bed and detoxified."

Dr Pittman returned home determined that St Louis should do something along the same lines. When he had started at the university there were six public beds available but patients diagnosed as alcoholics could stay only 48 hours. Then they had to leave.

The community has raised some money and with the aid of a federal grant, the first public alcoholic facility in Missouri was opened. But it was not enough.

By 1966 and with the assistance of Washington University, the police department, and a Catholic nursing order, North America's first detoxification centre was opened.

Quite apart from its punchy title, Dr Pittman points out that detoxification means something special. "It means the centre for the diagnosis, care, evaluation, and referral of alcoholic patients. At the same time it does not bring up the image of a place to treat a hopeless drunk."

"The idea that a physician can do anything with an alcoholic is a long time coming" . . .

. . . "The American Medical Society on Alcoholism has only 700 members out of 200,000 physicians" . . .

. . . "It is a hell of a lot better than it used to be, but there is still a hell of a long way to go."

In the beginning, there was a lot of opposition from local physicians who thought the centre smacked of "a night of debauchery on the town followed by breakfast in bed".

Looking back on the past 10 years, Dr Pittman observes: "If you have got the police and law enforcement agents on your side, they carry 10 times more weight than psychiatrists, or anyone else does, in handling what is traditionally called a 'police problem'.

The 45-bed pilot centre in St. Louis still functions well and is equipped for patients walking in on their own as well as those being brought in. The problems with the centre did not come immediately "because of an almost patriotic fervor which led the way to its opening.

"It is only after federal funding runs out and you need permanent sources of funds that problems can arise."

Dr Pittman said the initial aim was, "and still is, to have patients come back for a continuity of care that is successful. And emphasis should be put on 'success' because sometimes the problem with the medical profession in a public facility is that they never see cases that they have had success with."

Dr Pittman has also campaigned to get restrictions lifted on recovering alcoholics in public services.

"You cannot use the philosophy that alcoholism is a treatable illness without, in turn, removing the restrictions on recovering alcoholics."

Dr Pittman is irked by people "who always talk about the re-admission rate of patients.

"I don't think that question is ever posed in terms of the cancer patient or the diabetic patient — how many times has this patient been back into hospital?

"It is relevant information but it is not used as a justification for the denial of a service. If you accept the premise of the medical profession that alcoholism is a chronic illness then you can expect relapses in a number of cases.

After all, if any one of us gets lung cancer, we would not be chastized after the fact about the smoking of cigarettes."

Dr Pittman points out that in America the voluntary movement did not basically grow out of the ranks of the caring professions. It came from the victims themselves, their families, and informed citizens.

"The idea that a physician can do anything with an alcoholic is a long time coming. The American Medical Society on Alcoholism has only 700 members, I believe, out of 200,000 physicians.

"It is a hell of a lot better than it used to be, but there is still a hell of a long way to go.

"The attitude of the medical profession as a whole has been one of just benign indifference towards the problem. The alcoholic has been assigned to the psychiatrist by default. The psychiatrist has tried to make the alcoholic comfortable with his drinking instead of trying to get him to abstain."

With some 1,000 detoxification centres now in operation in North America, Dr Pittman has no time for those who like to bill them as "non-medical". "If they have medical backup and they are providing routine medical examination, it is sub-acute."

Calling them "non-medical" he feels, is selling a false bill of goods to the public. "If you want to try and sell cheap medical care you are still defeating the whole purpose that alcoholism is an illness that is deserving of adequate care."

Dr Pittman is also scornful of legislators and "the hypocrisy in statements of policy makers in Washington that alcohol is the number one drug problem—and then you look at the paltry appropriations that are being given."

But, "the thing I am more interested in now in terms of the purely social policy aspect of moving out of an academic environment and of trying to implement change in the community, in the state, and in the nation is the decriminalization of almost victimless crimes, in particular public drunkenness.

"It is coming but much slower than I ever anticipated."

Alcohol induces a protein loss

Dietary deficiency theory challenged

By David Milne

LAS VEGAS — Drinking 40% alcohol results in increased protein loss from the stomach, Dr Vincente P. Dinoso, Jr. told the 40th annual convention of the American College of Gastroenterology.

The protein-losing gastropathy is especially noticeable in patients with atrophic gastritis, said Dr Dinoso of the department of medicine, Hahnemann Medical College and Hospital, Philadelphia, Pa.

He reported on nine male and six female alcoholics ranging in age from 40 to 68 years.

Five had normal gastric mucosa, five had superficial gastritis, and five had chronic atrophic gastritis based on secretory tests and gastric biopsies.

All abstained from drinking for one week, then received 100 uci of ^{51}Cr labelled albumin intravenously.

During the control period the subjects drank 200 ml of orange juice at the rate of 50 ml every half hour for two hours.

During the test period they drank the same amount of 40% ethanol in orange juice at the same intervals.

During each period, plasma and stool samples were taken for four days and analyzed.

The results showed an increased loss of plasma in the feces while drinking, compared with the control group for all three types of subjects, with the loss being twice as much in those with chronic atrophic gastritis.

Additional studies in three patients showed that the increased ^{51}Cr-labelled albumin present in the feces originated mainly from the stomach.

In all three the plasma loss into the gastric lumen was greater after drinking.

"There appears to be a greater incidence of chronic atrophic and superficial gastritis in chronic alcoholics," said Dr Dinoso.

"Although hypoalbuminemia in noncirrhotic subjects with alcoholism is generally attributed to deficiency of dietary protein intake and diminished hepatocellular function, our observations suggest another mechanism namely, a protein losing gastropathy induced by chronic ethanol ingestion, especially in subjects with atrophic gastritis."

Vincente Dinoso

Mobile clinics conduct lung tests.

Lung ills are on increase in Quebec women and men

By Dorothy Trainor

MONTREAL. Lung ailments among Quebec women are on the increase, according to a Mount Sinai Hospital research team.

Cigarette smoking, air pollution, and the increased number of women in the labor force—perhaps working in polluted downtown areas—are cited as possible contributing factors.

"Things are worse than we anticipated compared to similar studies in England and the United States, especially with respect to the Montreal female population," Dr Michael Groszman, project coordinator and the hospital's medical director, told **The Journal.**

Mount Sinai Hospital, in Ste. Agathe, specializes in respiratory and chest diseases. This research team headed by Drs. Groszman and Michael Aronovitch, used mobile clinics to conduct breathing efficiency tests throughout Montreal, including polluted areas.

They found respiratory problems in both men and women surprisingly high—with women almost as likely as men to be affected. Between 20,000 and 25,000 of the 125,000 tested showed abnormalities. About 4% were abnormal and an additional 8% borderline.

The study showed links between chest disorders, cigarette smoking, age, and occupation. Lack of exercise was a factor as well as the number of cigarettes smoked.

"An individual who smokes a few cigarettes per day and quits may get rid of his lung abnormality, while those who smoke a lot may be stuck with theirs," Dr Groszman said.

"We tell people to stop smoking and they will be all right. But does this mean they will have clinical well-being or just that their chance of further deterioration will decrease?

"People say that living downtown is as bad as smoking, but where's the proof?"

In any event, the mobile clinic work has given the researchers a pyramid of statistics to evaluate. This will be done in an attempt to find some answers, and perhaps a common denominator in respiratory disease in the different target areas.

Ontario detox system

It appears to be failing in several ways

(continued from Page 1)

ARF's pilot project had shown that less than 5% of clients required medical care).

The objectives of the new system were to provide care and rehabilitation for the chronic drunkenness offender – those individuals, mostly on skid row, who were arrested more than three times a year for common drunkenness.

The principle aim was to remove the public inebriate from the criminal justice system to the health and social care system.

The ARF's analysis of 3,652 males and 504 females at six provincial detox units shows that the new system appears to be failing in several critical areas.

The major limitations outlined by Dr Smart include:

● The system does not seem to affect drunk arrests in large cities – it does not replace the revolving door. To do so, Dr Smart suggested, the system would have to be twice as large and limit itself to police referrals;

● The system does not provide enough impetus for long-term referrals. Only about 10% of those admitted take any kind of long-term care;

● The system does not appear to have effective treatment agencies for the detox population. Even among those who are referred, failure rates are high and the rate is not better for those who arrive than for those who don't;

● The detox-halfway house system *may* deteriorate into a new revolving-door. Perhaps, said Dr Smart, it would turn more quickly than the former jail door but have fewer people passing through it.

Drs Annis and Smart studied arrest figures for the six years prior to 1971 and for three post-detox years (1972-74). They found that over the six pre-detox years, arrests were decreasing slightly (e.g. 24,039 in 1966 to 22,094 in 1971).

However, with the opening of three detox units in Toronto (125 beds) this trend merely continued and there was no evidence the decrease was any greater after the opening of the new units.

The researchers also examined the arrest statistics for a large Toronto police division which included the skid row community.

They found only 9% of people arrrested for drunkenness actually went to a detox facility. Approximately 70% were refused at detoxes, most because they were full.

"It is not surprising that detoxes were not having much effect on arrests," Dr Smart reported.

"The difficulty is that extremely large numbers of beds are required for large North American cities."

The average length of stay is 3.9 days. To process 22,000 arrests a year, about 210 beds would be needed, just for police arrests. (Police have guaranteed access to only one-third of detox beds. Referrals from various other agencies and hospitals make up the remainder of referral sources).

Another 1975 study by Drs Annis and Smart concluded that the system was not having an appreciable impact on long-term rehabilitation.

A follow-up of 522 first admissions to three Toronto detox units showed 53% had one or more arrests within six months, mostly for alcohol-related offences. The average number of drunkenness charges was 4.3 per person. Less than half had no readmission to a detox during the follow-up period and only 9.6% of the detox admissions resulted in a referral to a health agency.

Many detoxes claim referral rates of 40% to 50% but only about a quarter of those actually arrive, the researchers reported.

A later follow-up of 115 men in 1975, two years after their admission, showed that only 23 were known to be sober or to have periods of sobriety.

"That would mean that about 5% of original detox admissions retained some sobriety over the longer follow-up period, although an additional 10% could not be found," Dr Smart reported.

"The picture obtained from this study is that detoxes are having a very limited effect on the lifestyles of their clientele. Few are going to detoxes when they are arrested. Only about 10% are taking confirmed referrals but most who do so have such short periods of treatment that recovery cannot be expected.

"We also found that readmissions do not result in more referrals, i.e. further contact with detoxes may not create much improvement."

Dr Smart said much more needs to be done to understand the functioning and effectiveness of the detox system, especially that involving the development of halfway houses.

In the meantime, he suggested that other options be considered.

These (options) could include:-

● long stays at detoxes for public inebriates and contracts for them to engage in treatment;

● a restriction of admissions to police referrals or public inebriates only;

● a mandatory period of stay, e.g. until a referral had been arranged and accepted.

Dr Smart concluded:

"All of this, of course, presupposes that we know how to treat public inebriates successfully and all that is needed is more opportunity to do so.

"However, this is almost certainly not the case and what is needed are more effective treatments, more efficaciously applied."

Canada plans anti-alcohol drive...

(continued from Page 1)

Family Physicians.

He said the policy is based on "persuasion and influence".

"I am not a prohibitionist—I am not even a teetotaller—but I believe strongly that alcohol must play a lesser role in our society.

"Advertising messages which consistently equate alcohol consumption with success, romance, and good times do not help to create the kind of environment in which we want to live," he said.

He described the three-part plan including:

● The national information program aimed at specific groups, such as schools and associations, and designed to increase social acceptability of abstinence and moderation;

● An effort to increase the effectiveness of current education and welfare programs, of industrial alcohol programs, and of professional groups involved in alcoholism treatment. Included in this effort, he said, is the storybook for children "The Hole in the Fence" and financial support for an education program for leaders in the alcoholism field, and

● Measures to control the manufacture, distribution and advertising of alcoholic beverages.

Lalonde said his department is trying to persuade provincial liquor control boards to take account of health questions in setting distribution regulations. He said a federal announcement on liquor advertising may be made "in the next few weeks".

...Lalonde upbraids family doctors

By Tim Padmore

HARRISON HOT SPRINGS, BC—Health minister Marc Lalonde told a British Columbia family physicians meeting here last month that they often let down their patients by failing to diagnose alcoholism.

Marc Lalonde

"Many Canadians—millions—go through your offices in a year. In many cases, the opportunity to make a simple inquiry about drinking or smoking habits is missed," he said during a luncheon address to the GPs' 21st annual scientific meeting.

Referring to the new emphasis of the College of Family Physicians of Canada on preventive medicine, he said:

"May I suggest that, especially in relation to alcohol problems, you, as family doctors, accept your roles as comforters and friends of your patients.

"Yes, it is highly desirable to *prevent* alcoholism, but it is also important to *help* people with alcohol problems, and the family physician can do both."

Earlier, Dr A. K. Connolly, director of treatment and training for the BC Alcohol and Drug Commission, made the same appeal.

He said there is "a host of signs" which should tip the physician off — for example, presence of a peptic ulcer or gastritis, evidence of family disharmony, or an aggressive personality.

Gastric symptoms imply a 50% probability of early alcoholism and family discord a 25% chance, he said.

"Once your suspicions are raised, you should ask direct questions—amount consumed, how often, etc."

He said physicians concerned about how much they drink themselves are sometimes reluctant to inquire about their patients' habits.

More next month from the International Conference on Alcoholism and Drug Dependencies held in Liverpool, England.

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Objectivity lost in pot debate

THE MARCH issue of **The Journal** included an editorial concerning the decriminalization of marijuana.

It did not urge decriminalization, it did not say decriminalization was better or worse than the state of limbo which exists in many jurisdictions today.

It simply stated a fact—that decriminalization was occurring in many places. And in light of that fact, it urged society to make adequate preparation to keep the potentially harmful health and social effects of marijuana use to a minimum.

The editorial espoused no view that should have been found objectionable by either the hawks or the doves.

But reaction there was, and some of it (as exemplified by one letter to the editor published in the April issue) proves once again that when it comes to discussion of this drug, emotion too often takes precedence over dispassion and objectivity.

In effect, we were attacked for urging a hasty progression toward a state of total decriminalization; for moving ahead before all the facts were known; for neglecting the massive weight of evidence showing marijuana use may be physically harmful.

But hold on. We said or implied no such thing. We proposed nothing more than that society earnestly, and thoroughly, study the best possible means of controlling the distribution of this drug, if and when it is decriminalized.

We took no sides, we did not proselytize, we simply asked for an objective appraisal of options. And perhaps there lies our fault, in the word "objective".

It seems more and more difficult to talk about any aspect of marijuana use without being pulled into a polemic, without being perceived as a mouthpiece for one side or the other.

When it comes to marijuana, polarity still continues to paralyze our reasoning.

If this issue of polarity was not such a critical factor in this marijuana debate, and if it was not such a prominent barrier to our coping with contemporary drug abuse, we would not use an editiorial to answer one letter.

Our ability to interpret, to reason, and most of all to listen, is vital to the development of appropriate responses for the chemical age.

Yet with marijuana, we suspend that ability and take up our adversary roles. We put on our team sweaters and try to bludgeon the opposition.

The adversary system is fine on the playing field, or in the courtroom where the goal is to win—for your side. But it is this preoccupation with "winning", and with battering the opposition, that continues to confuse the very individuals whose right it is to decide what role they want drugs to play in their lives.

These intellectual search-and-destroy tactics are destructive.

Every time a proponent of "free" marijuana stakes a claim his counterpart demands equal time—not to provide information that may help the person in the middle, but to discredit his opponent.

In the course of this exchange, scientific data is often manipulated totally out of shape. Objectivity, which is pretty hard to achieve under the best of conditions, doesn't have a chance.

We are now in the process of considering various legislative options in respect to cannabis. It is our position that we can make more rational choices if we know what the various options entail. To do that means cutting through the rhetoric and political underbrush to isolate the issues and to refine questions that need resolution.

That demands we take a look at things such as distribution models, control regulations, and educational programs not just "education" to frighten a child out of ever wanting to try pot, but to give him the kinds of information he needs to make mature decisions about drug use.

Discussing marijuana honestly, and looking at the social ramifications of its use, is not tantamount to endorsing it.

Unfortunately, there are still a lot of "experts" around who believe that to talk about marijuana in anything but sinister, derogatory terms, is to aid and abet the forces who would wish this "poisonous intoxicant unleashed on an unsuspecting public".

Then there are the opposing forces to whom any suggestion that marijuana may be harmful is hint of a fascist plot to erode civil liberties.

The tragedy is that the public, and those who can influence social policy, are caught in the middle.

"Success! Says he's sick and tired of listening to me complain about the high cost of food."

Letters to the Editor

More letters — page 12

Thebaine

Sir.

I have read Dr. P.R. Bourne's comments on "concern over poppies" which appeared in **The Journal** (February).

He states: "Thebaine can be readily obtained in the Middle East". I wonder from where in the Middle East and how could we get a few grams of thebaine for our research work?

Sükrü Kaymakçalan, MD
Professor and Chairman
Department of Pharmacology
Medical School, Sihhiye
Ankara, Turkey

Dealcoholization

Sir:

There is an aspect of the promotion of "dealcoholized" drinks which causes me considerable concern and I am surprised that it was not noted or mentioned in the "Back Page" article in **The Journal** (March). I refer to the danger of habituation to beverage use patterns that blur the distinction between drinking alcoholic beverages and drinking non-alcoholic beverages.

Has anyone studied the effect of the use of "dealcoholized" drinks on the non-alcohol drinkers to determine whether or not there is an increase in the number who become alcohol drinkers? Isn't the "aping" of alcohol drinking conducive to easy transition to alcohol drinking?

Why does the alternative to alcoholic beverages have to look, taste, and smell like those beverages? There are countless pleasant, refreshing, and relaxing drinks with no alcohol. It would appear that the real reason for wanting a dealcoholized drink that simulates the alcoholized drink is to keep the non-alcohol drinker from appearing "different". And when the non-drinker is no longer distinguishable from the drinker, one more barrier to everyone drinking will be gone.

It is not surprising that the alcoholic beverage industry is promoting this alternative. It will provide them with one more weapon in the efforts to get everybody drinking their wares. What better seed-bed for future alcohol drinkers could they find than "dealcoholized" beer and wine, even for the kiddies? It will pre-condition those remaining non-alcohol drinkers for their ultimate capitulation.

It is very tempting to try to lessen the ravages of alcohol use by cutting down on the alcohol content of the beverages used. What this "dealcoholized drinking" scheme looks suspiciously like is a training school for future drinkers of alcoholic beverages, rather than a way to get drinkers to drink less alcohol. The non-drinkers are already drinking less alcohol than the "dealcoholized" drinks will give them.

General Kitching and the LCBO may well be wiser than they have been given credit for being.

Harry W. Beardsley
Public Relations Manager
Preferred Risk Mutual
Insurance Co.
West Des Moines, Iowa

Backgrounder

This is the first of a series of Backgrounders on the US National Training System, and on federal-state relationships in the training of drug program workers.

US National Training System

— Part One —

By Milan Korcok

AS CRITICAL as manpower training may be to the strength of drug abuse programming, it is not what one would consider a "hot" political property.

Oh, they know it's there, and that training is part of the national effort, but politicians aren't as likely to play it to the balcony as they might treatment, or intervention, or law enforcement. That is, those few who want to talk about drugs at all.

And so, when President Ford recommended cutting the National Institute of Drug Abuse's manpower and training branch budget back from $14.7 million in fiscal year 1975 to $3 million in fiscal 1976, trainers across the country could do little but grin and bear it, and advise their employees not to take out any long-term mortgages.

Coming at a time when responsibilities for drug programming were so uneasily balanced between the states and the feds, and when the National Training System developed by NIDA was in such an embryonic stage, a cutback to $3 million would have been disastrous.

The National Training System is not the only mechanism available to provide training for drug abuse program counsellors, administrators, and managers. But there is no question it is the biggest show in town.

The National Training System is NIDA's chief effort to coordinate various training initiatives, to harness the resources and expertise only the feds can afford, and to move it out through a regional network to various training centres across the country.

The national system today (and it is necessary to note that what we are talking about now is going to be changed somewhat as of July 1, but more about that later) has at its hub the National Drug Abuse Center.

One of the chief functions of this centre is to develop and package courses to be used in the field. These courses cover such areas as working with youth; training of trainers; third party payments; women's concerns; and short term counselling. These are usually covered in one-week sessions.

Materials from the NDAC, in Arlington, Virginia, flow (at least thematically) to three Regional Resource Centers (Arlington, Chicago, and Berkeley) which in effect are field offices of the NDAC.

From here the materials and resources flow out to the five Regional Training Centers, which operate as conduits between the national resource, and the personnel and teaching facilities in the specific geographic regions.

Also operating out of DC, is the Career Development Center, which grew out of an earlier program which originally concentrated on the training of ex-addicts serving as program managers and administrators. The CDC is a successor to the National Institute for Drug Programs, which delivered a two-year AA degree program in human services.

The CDC has broadened its mandate to develop training links between people in the field (not just ex-addicts) and the various schools in their regions. It is concentrating heavily on non-traditional forms of study, off-campus learning, and assessing life experience in terms of educational credits.

Through a combination of badgering, persuading, and cajoling, the CDC has developed liaison with more than 300 universities and colleges, to harness some of their facilities and personnel for the training of drug abuse workers—ex-addicts as well as degreed people.

The National Training System is also responsible for development of physician education programs (for physicians in private practice as well as those working directly in drug programs), and it continues to support the career teacher program which allows for support grants to medical school teaching staffs for the development of curricula and drug abuse training modules in undergraduate medical education.

As the National Training System has developed over the past five years, manpower training strategies have been changing rapidly. So have jurisdictions. And the shift from federal to state responsibilities has confronted NIDA planners with certain dilemmas.

Just how much should the feds be doing at a time when the states are being told they are going to have to absorb many of the front line activities—training among them? The issue is loaded with pitfalls and vested interests.

Dr Stuart L. Nightingale, formerly director, Division of Resource Development of NIDA (now assistant director for medical and professional affairs), sees a continuing federal and technical presence, not a front line function, he says.

"Our overall approach is to build up the states, but how do you do it? Do you give them more money, or more specific guidance? I'm not sure," says Dr Nightingale.

What he seems to suggest is: If we give the states more money, how do we know they will spend it the way we think they should? And if we attach too many strings, will they even take it?

The fact is, most states have already shown they want money for direct services—for treatment, not training.

Almost seven years ago, the first of the Single State Agencies got underway. In effect they were supposed to provide a major cohesive and organizational function in each state. To help them cultivate the manpower training activities, NIDA primed the pump by granting $50,000 to each of the states if they would designate one training officer whose function it would be to serve as the focal point for bringing training capacity up to par.

This was called the STSP (State Training Support Program). There may be some exceptions, but generally this program has not lived up to expectations. The state training officers usually rank low on the state bureaucracy. Normally they are low paid, low priority people. The turnover has been prodigious. In the past three years, Florida has had five training directors.

Many states simply have not used their NIDA training grant money. This is frustrating not only for NIDA but for some state training sources who could use the money.

Some people at NIDA believe some states are squirrelling away training funds in anticipation of the STSP demise, so they might subsequently use that money for direct services.

In a recent evaluation of the National Training System, the National Association of State Drug Abuse Program Coordinators charged the system with failing to meet the needs of state and local training programs.

Most states want actual training courses delivered right to the program site. They want the feds to be more responsive to the individual needs of specific states, and they don't want to be force-fed courses pre-packaged by NDAC.

The majority of states want the NDAC, the Regional Resource Centres, and the Regional Training Centres either abolished, or changed.

The bottom line appears to be: "Give us the money, we can do it better."

Given this kind of response from the states, plus the prospect of impending budget cuts, NIDA took a pretty hard look at its system and concluded changes were in order. Of course, if President Ford's request for $3 million held up there would be little left of the system anyway.

Luckily, Congress restored a $10 million budget. And though this is still a 50% reduction from the previous year, it would allow a reasonably solid reformation of the national training system, with not too much being dropped in the process.

(Most of the $5 million reduction is to be accounted for by various program grants that were running out.)

Under the new budget, and within the revised training system, the Career Development Center will continue, says Dr Lonnie Mitchell, Chief, Manpower and Training Branch of NIDA. The state programs and contracts will continue as will the physician education program, and the career teacher program. The training functions at the NDAC will continue although in a "somewhat scaled down" version, he says.

The most significant change in the National Training System will be the consolidation of the five Regional Training Centers and the three Regional Resource Centers to make up five Regional Support Centers. Each of the five will continue to serve the regional areas now designated, although the headquarters might change.

In effect, this gives more backup resource to the RTCs and brings the NDAC, through its field offices, into closer communion with the states: Thus the major recommendation made by NASDAPC in its recent evaluation is met.

The changes are to take place by July 1, 1976. What remains to be done between now and then is to settle on the locations of the Regional Support Centers. At least 70 requests have already been filed by various institutions and programs in pursuit of the five contract slots.

Inside Science

Alan Ogborne is a research scientist with the Addiction Research Foundation of Ontario

By Alan Ogborne, PhD

IN RECENT years the government of Ontario has actively encouraged the development of non-custodial facilities for public inebriates.

The provincial ministry of health currently funds 13 detoxification centres which admit people found drunk in public, and the ministry of community and social services funds 17 halfway houses (or recovery homes) which aim to facilitate the rehabilitation of alcoholics after detoxification.

The Addiction Research Foundation of Ontario, which was influential in the province's decision to fund detoxes and halfway houses, currently runs two experimental residential programs for public inebriates—Bon Accord Farm and 142 Spadina. The Clinical Institute is also active in this field and is responsible for a detox centre on Dundas Street in Toronto.

Foundation scientists have undertaken the monitoring of the provincially funded detoxes and halfway houses and the foundation's own programs are participating in the monitoring systems. Directors and staff of both types of facilities have cooperated with ARF staff by keeping appropriate records.

The aims of the halfway house monitoring study parallel those of the monitoring study being conducted in the detoxes by Dr Helen Annis and her team.

Briefly, the halfway house study aims to learn about the characteristics of the men and women who go to halfway houses and to determine the extent to which such houses are attracting the public inebriates who have traditionally been caught in the revolving door of the drunk tank. Further, the study of halfway houses aims to monitor residents' length of stay, and mode of discharge from houses.

Follow-up studies will be conducted to determine the extent to which former residents of the houses achieve sobriety, social integration, and stability. A particular concern of follow-up will be to examine the prospect that halfway houses (and detoxes) become further stations on the skid row circuit rather than act as rehabilitation agencies.

The houses taking part in the monitoring study offer a wide range of programs to their residents. Staff of some houses aim primarily to provide a homelike environment which can be a base from which residents operate to re-establish themselves in the outside world with the help of appropriate community resources.

Other houses are more structured and therapy oriented and hold regular groups or individual counselling sessions which aim to bring about changes in their residents.

Some houses make more use of Alcoholics Anonymous than do others; some prefer residents to have had treatment in hospital prior to admission while others take residents literally off the streets. Some houses make more use of professional rehabilitation counsellors.

The use of the multi-variable statistical analyses will enable researchers to consider the likelihood that some houses are more suitable for certain types of residents than for others. "Natural" experiments caused by staff changes may approximate experimental manipulation of program elements and thus allow a testing of the value of these elements. In general, however, such possibilities are expected to be limited and it is to the foundation's own program—Bon Accord and 142 Spadina—that one must look for the rigorous testing of potentially valuable features of residential programs for the public inebriate.

Research staff are trying to make the exercise as valuable to house staff as possible and have been providing regular feedback on resident characteristics.

A preliminary report on results from a dozen houses has been prepared and two colleagues, Sarah Weber and Virginia Ittig, and I have presented these results to the house staff at the annual conference of the Recovery Homes Association of Ontario.

The research will be continuing for some years to come, by which time we should have some clearer understanding of the true role of halfway houses in the rehabilitation of alcoholics.

Alan Ogborne

COLLISION COURSE

Content and Purpose

"Collision Course" is a dramatic essay which explores the potentially tragic consequences of mixing even moderate amounts of alcohol with the complex task of driving.

It is designed to impress upon the viewer that one is at risk even when generally socially-acceptable drinking behavior is practised.

The viewer is introduced to a young middle-class couple and their parents. The film follows the young couple's activities throughout the evening; taking in a movie and having a few beers with friends. At the same time, their parents are discussing some known facts relating to problems contributing to the carnage on the roads. Also introduced is a blue collar worker who, after a tiring day on the job and a couple of after-work drinks, takes to the highway.

The film dramatically analyzes the behavior of the indviduals involved and their subsequent actions.

As the audience is geared to suspect from the first, the young couple and the blue collar worker eventually meet . . . in the middle of the night on a lonely road.

Audience and Use

Collision Course is an action film which is ideal for use with a variety of audiences (e.g. driver education programs, driver training courses, home and school associations, student groups, community action groups). Community workers in the alcohol and drug dependency field will find this film a valuable teaching aid in the exploration of legal, social and behavioral aspects of drinking-driving issues.

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This film will not be available until May 7, 1976

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Around the World

Scots are ahead

The percentage of alcoholics is four times greater in Scotland than in England, and in the Highlands and Scottish islands the problem is 12 times greater. Official statistics show two per cent of Scotland's adults are alcoholics with unofficial estimates much higher.

Pricey Iceland

A bottle of vodka in Iceland now costs $21 and a pack of cigarettes $1.20 after the government announced price increases that will also affect costs of public transportation, water, and state licences for television sets.

A vicious cycle

Russian doctors confirm that a combination of poor educational opportunities, crowded living conditions, and a low standard of living in early stages of life will lead to a vicious self-perpetrating cycle of alcohol abuse, to be repeated generation after generation. A contributing factor to alcohol abuse, they say, is the Russians' belief that a vast capacity for alcohol is held to be an indispensable characteristic of a sociable nature.

Cocaine traffic

Colombian officials have met with US Secretary of State Henry Kissinger to discuss efforts to suppress the illegal smuggling of cocaine into the US. The drug is often sarcastically referred to as Colombia's second leading export after coffee. As much as $500 million worth of Colombian cocaine ended up in the US last year.

Drug exports zoom

Exports of pharmaceuticals in 1975 increased by nearly 25% in Britain over the previous record-breaking figure of £301.6 million achieved in 1974 to £373 million. Those countries that increased their purchases significantly were the US, West Germany, and Japan.

Hashish habits

With about 30 tons of hashish smuggled into Egypt each year, officials there estimate between 100,000 and 200,000 people are regularly using the drug despite the harsh sentences imposed on those caught by police. Possession and dealing can mean the death penalty or hard labor for life. Possession of hashish for personal use can lead to imprisonment for between three and 15 years.

Poisonous wines

Wine laced with methyl alcohol is being tracked down after 14 people died in Hong Kong after drinking it. Police cracked down on two major manufacturing centres of the poisonous wine, discovered a wine shop believed to be a principal supplier of fake Chinese wine labels, and raided a printing factory, seizing more than 20 boxes of fake wine labels.

'Your breath stinks of stale tobacco'

Britain's Health Education Council will soon end an intensive four-month anti-smoking campaign which is aimed specifically at teenagers. The campaign, with an estimated cost of $400,000, attempted to achieve the most impact by focusing on short, blunt messages on posters and television commercials, (above).

Receptionists 'prescribing' too often

LONDON—Too many receptionists in the offices of family physicians in Britain are writing prescriptions for drugs and their power to do so should be severely limited.

This is the conclusion of Pharmacist Arthur Wells who says that at the end of the month when he examines prescriptions handed in to his drugstore in Maidstone, Kent, he finds that more than 50% have been written by receptionists.

"Many of them appear to call for excessive quantities of drugs and 90% had no dose or instruction of any sort," he said.

Mr Wells said receptionists themselves are not at fault: They are doing a thankless job and their position has never been clarified.

He added: "I do not believe any prescription should be written by anyone other than the doctor who signs it."

Mr Wells made his observations in the *Pharmaceutical Journal*.

Doubt cast on prevention efforts

By Lachlan MacQuarrie

MANILA — A study commissioned by the Narcotics Foundation of the Philippines and carried out under the direction of Dr Ricardo M. Zarco of the University of the Philippines has raised doubts here about the effectiveness of programs of drug and alcohol prevention.

This study, called Project Serendipity, focused on 20 male clients—the total inmate population of a drug rehabilitation centre.

The purpose of the study was to gain information about how much drug abusers knew about the adverse effects of drug taking before they started to use drugs.

"It was commonly assumed," states Dr Zarco, "that drug taking is primarily due to the inability of the family, school, or other institution to warn the youth against the improper use of dangerous drugs.

"For this reason the programs to counteract drug abuse are governed by the information principles — by the use of direct information or by threat or fear."

In this connection, a concentrated educational program was launched in the Philippines in 1970 which included the dissemination of anti-drug material in comic books, posters, radio-TV plugs, pamphlets and books, films, and school-sponsored seminars or lectures on drugs.

The campaign was maintained through 1973, and the period corresponded generally with the time when the 20 respondents were using drugs.

The principal method used in Project Serendipity was a series of interviews beginning with a pre-test of a semi-structured schedule and progressing to subsequent interviews where the final refined and more structured schedule could be used.

Each respondent was interviewed at least twice by different interviewers in order to test data reliability. The average age of the 20 respondents was 19.5 years, and the average age of starting to use drugs was 14.3 years.

The study found that the majority of respondents had, before beginning to use drugs, gained considerable information about drug abuse from informal sources such as the home, family, and friends.

Of the group, 65% had prior knowledge from these informal sources about the health consequences of drug abuse; 65% realized that schooling would be affected; 60% were aware of the legal consequences; and 60% had received direct warnings from relatives and friends about drugs.

From the more formal sources of information such as the school and the mass media, a somewhat lower percentage of recalled exposure is reported with 45% recalling exposure to comic books, posters and radio/TV plugs; 30% having read pamphlets and books; and 10% having attended seminars or lectures at school. None of the respondents recalled seeing an anti-drug film.

The study concludes: "The commonly held belief that youths turn to drugs because of their ignorance of the dangers, nature, and consequences, as well as their not being directly warned by their family and associates, is not reasonably supported by the findings.

"This study shows that drug abusing youths had a high level of awareness of the drug danger before they used drugs. Knowledge came mostly from informal sources and secondly from mass media (formal) anti-drug messages."

Even more respondents recalled exposure to anti-drug information after they had started to use drugs. Warnings, lectures, and other information from family and friends were received by 95% of the group at this later stage; and more than 80% said that while they were using drugs they had seen and heard such anti-drug material as posters, pamphlets, comic books, and radio/TV plugs.

Dr Zarco's report describes the epidemiological element involving the spread of drug taking from one young person to another.

"What is very clear is the contamination, seduction, or influence of drug abusing youths who 'turn on' others to take drugs too. This seems to be the critical variable. Membership in a drug abusing group gives feelings of security to abuse drugs because others do the same. They learn the methods of drug enjoyment suggested by the group, and become immune or impervious to anti-drug information."

Dr Zarco acknowledges that the study may be somewhat limited by the fact the investigation did not use a control group, and by the small number of cases.

Nevertheless he says the study indicates that prevention programs are futile if the main strategy is based on the assumption that knowledge is sufficient deterrent to behavior.

"In our search for a quick and easy means of preventing drug abuse", he concludes, "we have adopted, possibly, the most ineffective."

New Zealand study

Alcohol, murder linked

AUCKLAND, NZ — Alcohol was associated with one third of the cases of psychiatrically-disturbed individuals charged with murder or attempted murder over a 35-year period, a New Zealand psychiatrist has reported.

The study by Professor R. W. Medlicott, director of Ashburn Hall, a psychiatric hospital in Dunedin, covered 28 people charged with murder and 10 charged with attempted murder.

"It is well known that alcohol releases aggressive impulses and chronic heavy drinking disorganizes the life pattern of the individual and his family," he reported in the *New Zealand Medical Journal*.

"Drunkenness was a major factor in five of those charged with murder, and a lesser factor in three others. In an even higher proportion (half) of those charged with attempted murder, the use of alcohol released hostile acting-out which would probably have been contained if the individual had not been drinking."

Ages in the group ranged from 14 to 62 years. The male-female ratio was 5:3.

UK women and youths increasing alcohol use

LONDON—Trends in Britain's drinking habits indicate the number of alcoholics may reach a million and a half by the end of this decade, according to the Health Education Council here. And this could well be only the tip of the iceberg, with millions more indirectly affected by alcoholism.

The council has sent a set of disturbing new statistics together with expert background commentary and resource and publicity advice to health education officers throughout the country.

The council hopes that the resource pack— one in a series covering a number of major health problems—will help to stimulate local awareness of the problem to aid educational campaigns.

"As a nation, we are drinking more and more—and there is a disturbing increase in alcohol abuse among the young," comments a spokesman for the council.

Offences of drunkenness in the 14-17 age group jumped by 32% in 1974. There is a serious increase also in the number of female alcoholics. Ten years ago, the proportion of male-to-female alcoholics was approximately eight-to-one. By 1973, the proportion had dropped to four-to-one.

The council estimates there are about 300,000 alcoholics in employment throughout the United Kingdom. Assuming each of them loses in excess of three working weeks each year through alcohol-related illness, the loss of production costs employers close to $100m annually.

A similar calculation for excess amount paid out in sickness benefit results in an annual figure of nearly $50m. Alcohol consumption generally increased by 37% in the past four years and annual consumption in 1974 alone was three times greater than in the previous three years.

More Letters...

(continued from Page 8)

Qualifications

Sir:

With regard to the Backgrounder (Feb 1, 1976) which quoted the British Columbia manual for staff accreditiation as saying: "It is also true, however, that inestimable damage has been done by concerned people whose only qualification has been good intentions and a sentimental need to help."

Is it not also true, however, that inestimable damage has been done by concerned and unconcerned people whose only qualification for helping others is a wall lined with academic degrees and credentialing certificates? And the question of whether a trained, helping person is an advantage over an untrained one hardly merits an "unequivocal yes". Such a response seems to ignore the research suggesting that in the very process of completing some training programs, the characteristics most essential to helping others are effectively trained out. We are hardly to the point of unequivocalness on this question.

It is hoped that such unequivocalness combined with eagerness to credential does not lead to an over-emphasis on academic degrees and, in turn, the basing of the reward structure (salary allowances and organizational prestige) on those degrees. If it does not, it will be a unique exception to the professionalism process which once initiated proceeds rather rapidly. Certifying and/or rewarding counsellors for their ability to suffer through the initiation rites of degree accumulation, rather than the results of their reaching out to help those in need of help, is not necessarily an advantage for the alcoholics of the nation.

Credentialing should be commensurate with respect to the knowledge of treatment effectiveness. Given the low level of effectiveness of all treatments, credentialing should probably not be a priority item of concern. More important concerns for those involved in treatment would be: reaching the target population; and having reached the target population, how is it effected by the actions of the helpers?

The answers to these questions may then lead to a responsible credentialing process based on minimal requirements of effectiveness that can be acquired with training. Until that time, credentialing should continue to play a very limited role in the functioning of treatment centres, and especially in its reward allocations. Assigning it a premature high priority status may well inhibit any real progress in helping alcoholics.

Jerry Fitzgerald
Iowa City, Iowa

Four months into liberalized pot laws

'Good' and 'bad' news from California

By Saul Abel

LOS ANGELES — Three months after a liberalized marijuana law went into effect in California, reports on its effects in the state's largest metropolitan area indicate a mixture of "good news and bad news".

The "good" news is there has been a sharp drop in marijuana arrests in Los Angeles.

The "bad" news is there has been a sharp rise in marijuana seizures in Los Angeles.

Some authorities are frank to state they cannot explain this apparent inconsistency, while others suggest a variety of possible causes.

Commander Peter F. Hagan of the Los Angeles Police Department (LAPD) told **The Journal** seizures of marijuana shipments coming into the area thus far this year are virtually double the level one year ago.

The new marijuana law, reducing penalties for simple possession, is a factor in the increased importation of the drug, Hagan contends, because it confers a kind of "passive blessing" on marijuana use.

Why, then, hasn't this also brought an increase in marijuana arrests?

Before passage of the new law, anti-reform spokesmen issued dire warnings of mushrooming use of the drug. Instead, there were less than 500 marijuana arrests in January and February of this year, compared to more than 1,100 such arrests in the corresponding period of 1975.

One reason for the decrease, Hagan suggested, may be that discovery of marijuana generally occurs in connection with the investigation of another crime, such as burglary or assault. In such cases, the suspect is charged only with the more serious offence.

Another view of the drop in marijuana arrests is that it reflects greater attention by police to major suppliers and less attention to the small user.

LAPD Chief Edward M. Davis has offered another explanation: "Perhaps our officers are saying that no one gives a damn, that it just isn't worth the time," he said recently.

Asserting that in today's polydrug culture the marijuana cigarette is frequently the introductory device leading to heroin use, Davis predicts the number of heroin addicts in Los Angeles county will double within a year, reaching approximately 97,000.

He also foresees a doubling of overdose deaths, totalling about 500 in Los Angeles and about 1,000 throughout California this year.

Some confusion has resulted from other aspects of the new legislation. Several incidents have been reported of people who mistakenly believed the new regulations legalized use or possession of marijuana. Police officers have been visiting schools to combat such misunderstanding, and to advise school officials of the exact changes in the law, according to LAPD Commander Barry Wade.

A legal question which may create problems was cited by Gerald F. Uelman, professor of law at Loyola University in Los Angeles. The statutory definition of marijuana includes all parts of the cannabis plant except the mature stalks (excluded because they are used in making hemp rope) and the sterilized seeds (excluded because they are used for canary food), according to Prof. Uelman.

It is practically impossible to say how much of a given quantity of processed marijuana came from the stalk and how much from the stem or leaf, he said. Similarly, unless the marijuana seed is planted and watered, it cannot be determined which seed is sterilized and which is capable of germinating. Marijuana is also often mixed with tobacco or parsley, he noted.

All these factors compound the legal difficulties in deciding whether a defendant charged with possession of a quantity not much more than an ounce is subject to only a fine for possession of less than one ounce, or subject to imprisonment for possession of more than one ounce.

This problem was avoided in the new heroin law, Prof Uelman pointed out, by specifying the offence to be possession of "a substance containing heroin".

New Books

by RON HALL

Alcohol Control Policies In Public Health Perspective

. . . by Kettil Bruun, Griffith Edwards, Martti Lumio, Klaus Mäkelä, Lynn Pan, Robert E. Popham, Robin Room, Wolfgang Schmidt, Ole-Jorgen Skog, Pekka Sulkunen, and Esa Osterberg.

Addiction Research Foundation, (33 Russell Street, Toronto, Ontario. M5S 2S1), 1975. 106p. $8.

This collaborative report is presented as a position paper which is intended to stimulate debate and renew interest in the importance of control policy in the prevention of alcohol problems. Consumption of alcohol is related to physical health problems and mortality; and statistics, as well as trends in consumption and production are presented. A chapter on alcohol control policies investigates various measures including: price control, hours of sale, and alcohol content.

Narcotic Antagonists: The Search For Long-Acting Preparations

. . . edited by Robert Willette

National Technical Information Service, (US Department of Commerce, Springfield, VA 22161), 1976. 51p. $4.

This monograph reviews current work in developing either a mechanical or chemical pharmaceutical preparation which is capable of providing a sustained or long-acting effect. In this case, the "delivery system" using naltrexone was investigated.

Cannabis And Culture

. . . edited by Vera Rubin Mouton Publishers, (Aldine Publishing Company, 529 South Wabash Avenue, Chicago, Illinois 60605), 1975. 612p. $24.95.

This volume draws together the information to enable an understanding of the wide range of uses of cannabis in a variety of countries. The botany and pharmacology, the history of diffusion and use, and the effects of use in social and cultural contexts are presented; and legal, medical, and psychiatric aspects are also examined.

Alcohol and Blacks: An Overview

. . . by Frederick D. Harper Douglass Publishers, (Box 3270, Alexandria, VA 22302), 1976. 21 p. $1.25.

In response to a need for information on alcohol and its effects in the Black community, the author discusses drinking behavior and practices, etiology, criminal aspects, treatment and counseling; and he offers recommendations which might be useful to Black alcoholics, their families, and alcohol professionals.

Young Men And Drugs — A Nationwide Survey

. . . by John A. O'Donnell, Harwin L. Voss, Richard R. Clayton, Gerald T. Slatin, and Robin G. W. Room.

National Technical Information Service, (US Department of Commerce, Springfield, VA 22161), 1976. 158p. $6.75.

The results of a survey of the nonmedical use of psychoactive drugs among young men in the United States are presented in this report. The best estimates of use indicate that during their lifetime 97% of those responding have used alcohol, 70% have used cigarettes, and 55% have used marijuana; but that currently the use rates are 92%, 60%, and 38% respectively. Rates for use of other drugs are presented, and other topics including: attitudes, motivation, crime, multiple drug use, treatment, and regional variations in use, are discussed.

Other Books

Pharmacology, Toxicology and Abuse of Psychomimetics (Hallucinogens) — Raduco-Thomas, Simone, Villeneuve, A., and Raduco-Thomas, C. (eds.) Les Presses de l'Universite Laval, Quebec, 1974. 473p. $18.80

Such Und Missbrauch: Köperliche und Psychische Gewohnung sowie Abhangigkeit Von Drogen, Medikamenten und Alkohol — Steinbrecher, W., and Soms, H. (eds.) Georg Thieme Verlag, Stuggart, 1975. "Addiction and Abuse: Physical and Psychological Habituation and Dependency on Drugs, Medication and Alcohol." 861p.

Die Hashichsucht: Pharmakologie, Geshichte, Psychopathologie, Klinik, Soziologie — Stringaris, M. G. Springer-Verlag, New York, 1972. "Hashish Addiction: Pharmacology, History, Psychopathology, Clinical Aspects, Sociology." 150p. $9.45.

Becoming Naturally Therapeutic — Small, Jackquelyn, Texas Commission on Alcoholism, Austin, 1974. "A handbook on the art of counselling with specific application to alcoholism counsellors." 55p.

A Guide To Community Organizations for Alcoholism Services — Wynne, Ronald E., Wynne, Suzan, Kendrick, James E., Churgin, Shoshanna and Lynch, Richard. Wynne Associates, Washington, 1975.

Alcohol in Colonial Africa — Pan, Lynn, Finnish Foundation for Alcohol Studies, Helsinki, 1975. 121p.

In the Magic Land of Peyote — Benitz, Fernando. University of Texas Press, Austin, 1975. 198p. $9.75.

Care of Custody — Tutt, Norman. Agathon Press, New York, 1975. "Community homes and the Treatment of Delinquency." 226p.

Coming Events

Treatable Aspects of Alcoholism—May 5-7, 1976, Thunder Bay, Sault Ste. Marie and Sudbury Ontario. Information: Dr Hector Orrego, Addiction Research Foundation, 33 Russell St., Toronto, Ontario, M5S 2S1.

National Nurses Society on Alcoholism Second Annual Meeting—May 6-7, 1976, Washington, DC. Information: Juanita Palmer, Chairwoman, Program Operations Committee, 2 Park Ave., Suite 1720, New York, New York, 10016.

Work in Progress In Alcoholism—May 6-8, 1976, Washington, DC. Information: National Council on Alcoholism, 2 Park Ave., New York, New York, 10016.

New Concepts 111 "The New Woman and Alcoholism"—May 7-8, 1976, Lincoln, Nebraska. Information: Connie Clark, Community Awareness Coordinator, Lincoln Council on Alcoholism and Drugs Inc., Room 212, 215 Centennial Mall, Lincoln, Nebraska, 68508.

Annual Meeting of the American Psychiatric Association—May 10-14, Miami Beach, Florida, Information: Mr R. L. Robinson, APA, 1700 18th Street, NW, Washington, DC 20009.

Alcohol and the Liver—May 14, 1976, Toronto, Ontario. Information: The Canadian Hepatic Foundation, Suite 1010, 65 Queen St. E., Toronto, Ontario, M5H 2M5.

Alcoholism and Drug Abuse: 1976—May 22-23, 1976, UC-San Francisco. Information: Alcoholism and Drug Abuse: 1976, 731 Market St., 5th Floor, San Francisco, California, 94103.

The High Cost of Alcoholism—May 26-27, 1976, Louisville, Kentucky. Information: Joe Trabue, Department of HPER, University of Louisville, Louisville, Kentucky, 40208.

The Annual Conference of the National Coordinating Council on Drug Education—June 2-5, 1976—Minneapolis, Minnesota. Information: National Coordinating Council on Drug Education, 1526 18th St., NW, Washington, DC, 20036.

Annual Meeting of the Halfway Houses of North America — June 6-10, 1976, Edmonton, Alta. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

22nd International Institute on the Prevention and Treatment of Alcoholism—June 7-12, 1976, Vigo, Spain. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

The Committee on Problems of Drug Dependence—June 7-9, 1976, Richmond, Virginia. Information: Committee on Problems of Drug Dependence, NAS-NRC, 2101 Constitution Ave., NW, Washington, DC, 20418.

Ninth Annual Eagleville Conference on Alcoholism and Drug Addiction—June 10-11, 1976, Eagleville, Pennsylvania. Information: Patricia Moretti, Conference Registrar, Eagleville, Pennsylvania, 19408.

Eleventh Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies, INFORMACTION—June 20-25, 1976, Toronto, Ontario. Information: William Gilliland, Conference Manager, Addiction Research Foundation, 33 Russell St., Toronto, Ontario, M5S 2S1.

Rap Round-up 1976—June 25-27, 1976, Swan Lake, New York. Meeting of recovered alcoholics who are working in the professions. Information: RAP, Box 95, Staten Island, New York, 10305.

Sixth International Institute on the Prevention and Treatment of Drug Dependencies—June 28-July 2, 1976, Hamburg, Germany. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Potsdam Institute on Alcohol Problems—July 12-23, 1976, Potsdam NY. Information: Dr Louis LaGrand, Institute Director, State University College, Maxcy Hall, Potsdam, NY.

Eleventh International Conference on Medical and Biological Engineering—Aug. 2-6, 1976, Ottawa, Ontario. Information: Conference Office, National Research Council, Ottawa, Ontario, K1A 0R6.

17th Institute on Addiction Studies—Aug. 15-20, 1976—McMaster University, Hamilton, Ontario. Information: David E. Reeve, 15 Gervais Dr., Suite 603, Don Mills, Ontario.

Symposium on Drug Dependence, Alcoholism and Criminality — Aug. 16-20, 1976, Sao Paulo, Brazil. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Ninth International Conference on Health Education—Aug. 29-Sept. 3, 1976, Ottawa, Ontario. Information: Canada's Organizing Committee, Ninth International Conference on Health Education, c/o Canadian Health Education Specialists Society, PO Box 2305, Station D, Ottawa, Ontario, K1P 5K0.

Second International Symposium on Victimology — Sept. 5-11, 1976, Boston, Massachusetts. Information: 156 Federal St., Boston.

27th Annual Meeting of Alcohol and Drug Problems Association of North America—Sept. 12-16, 1976, New Orleans, Louisiana. Information: ADPA, 1101 Fifteenth St. NW, Washington, DC, 2005.

First World Conference on Therapeutic Communities—Sept. 27-Oct. 1, Katrineholm, Sweden. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism—Oct. 20-23, 1976, San Diego, California. Information: Pamela Maroe, ALMACA, Suite 410, Reston International Centre, 11800 Sunrise Valley Dr., Reston, VA, 22091.

In order to provide our readers with adequate notice of forthcoming meetings, please send announcements as early as possible to: The Journal, 33 Russell Street, Toronto, Ontario M5S 2S1.

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Dr. Irving Rootman, Health and Welfare Canada

MEDICAL MANAGEMENT OF ALCOHOLICS AND DRUG DEPENDENT INDIVIDUALS
Dr. Albert Nantel, University of Laval, Quebec

PHARMACOTHERAPEUTIC APPROACHES IN ALCOHOL AND DRUG DEPENDENCE
Dr. Carl Pinsky, University of Manitoba

ALCOHOLISM AND OTHER DRUG DEPENDENCIES: A PRIVATE ILLNESS
Dr. George Strachan, Gillain Foundation, Victoria, B.C.

BEHAVIOURAL THERAPIES—OR PERSUADING PEOPLE TO BE DIFFERENT
Dr. Charles Aharan, The Victoria Life Enrichment Society, B.C.

SOME MODELS FOR THE PREVENTION OF ALCOHOLIC PROBLEMS
Dr. Wolfgang Schmidt, Addiction Research Foundation

CURRENT PROGRESS AND RESEARCH IN ALCOHOL AND DRUG EDUCATION
Dr. Michael Goodstadt, Addiction Research Foundation

DETOXICATION: ALTERNATIVES TO THE HANDLING OF PUBLIC INEBRIATES
Dr. Helen Annis, Addiction Research Foundation

INTERNATIONAL ASPECTS OF DRUG PROBLEMS
H. David Archibald, Executive Director, Addiction Research Foundation

SOME PERSPECTIVES ON DRINKING AND DRIVING
Ernie Pass, N.S. Registry of Motor Vehicles, Halifax, N.S.

IMPROVING THE REFERRAL SYSTEM: HOW TO GET THE CLIENT TO THE AGENCY
Dr. Peggy-Anne Brown, University of Alberta

SPECIAL INTEREST SESSIONS

Over 100 papers will be presented including:

PRINCIPLES OF TREATMENT FOR WOMEN ALCOHOLICS
Doreen Birchmore, Donwood Institute, Toronto

PROFILE OF THE SPOUSE OF THE ALCOHOLIC
Manfred Winter and Edith Larson, Calder Rehabilitation Center, Saskatoon

THE EXTENT OF THE ALCOHOL PROBLEM IN LABRADOR
Richard A. Boczkowski, Government of Newfoundland and Labrador

CHILDREN OF ALCOHOLIC PARENTS
Margaret H. Hindman, NCAI, Rockville, Md.

THE CHILD, ALCOHOL AND ABUSE
D. Frank Worrell, Alberta Alcohol and Drug Abuse Commission

COMMUNITY DETOXIFICATION SYSTEM—A SELF HELP MODEL
Bill Cline, Govt. of the Yukon Territory

DEVELOPMENT OF A TREATMENT MODEL FOR ALCOHOLICS
Dr. Z. Amit, Sir George Williams Faculty of Arts, Montreal

DISULFIRAM IMPLANTS FOR ALCOHOLISM
Dr. Allan Wilson, University of Manitoba

EVALUATION DU TOXICOMAINE EN CABINET DE PRATIQUE GENERALE
Dr. Michelle Cousineau, Medecin Conseil—Toxicomanies, Montreal

THE THOUGHT DISORDER OF THE CANNABIS SYNDROME
Dr. Alfred V. Milliman, Maryland Drug Abuse Research & Treatment Foundation

DEMONSTRATIONS

In lieu of field trips, representatives from treatment facilities in the province will demonstrate their methods at the conference.

A NETWORK OF COMMUNITY SERVICES FOR THE ALCOHOLIC
John Egan, Smith Centre, Thunder Bay
Bob Smith, Lawkin Centre, Thunder Bay

PINEWOOD CENTRE ALCOHOLISM PROGRAM
Dr. George Blake, Oshawa

OBJECTIVE SETTING AND COMMITMENT MONITORING WITH SKID ROW INEBRIATES: BON ACCORD'S BEHAVIOUR REVIEW GROUPS
Rev. D. F. Collier, Bon Accord, Elora

TEACHING COPING STRATEGIES TO PROBLEM DRINKERS: THE APPLICATION OF SELF-HELP STRATEGIES IN AN ALCOHOLIC HALFWAY HOUSE
Dr. Martha Sanchez-Craig and Keith Walker, Spadina Project, Toronto

MAY STREET TREATMENT PROGRAM
Dr. E. Freedberg, Addiction Research Foundation

ADDICTION RESEARCH FOUNDATION CLINICAL INSTITUTE TREATMENT MODEL
Dr. Fred Glaser, Head of Psychiatry, Addiction Research Foundation

SYMPOSIA

FORMATIVE EVALUATION FOR PROGRAM DEVELOPMENT
Dr. Stephen L. Milstein
Institut National de la Recherche Scientifique-Sante Universite du Quebec, Montreal

BROAD SPECTRUM BEHAVIOURAL STRATEGIES WITH ALCOHOLICS
Dr. George Blake
Pinewood Centre of Oshawa General Hospital
Oshawa, Ontario

NARCOTICS AND ALCOHOL TREATMENT PROGRAMS IN MONTREAL AND VANCOUVER
Raymond D. Cohen
Director, Alternatives Program for Alcohol and Drug Dependencies
Vancouver, B.C.

ALCOHOL/DRUG ISSUES AFFECTING YOUTH
Gail Swainston
Toc Alpha
Alcohol and Drug Concerns
Toronto

SIMULTANEOUS TRANSLATION FACILITIES will be provided at all plenary sessions and at selected afternoon sessions.

AUDIOTAPES of all plenary sessions will be available at the conference.

PLENARY PAPERS will also be reproduced in the conference program book.

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Send to: **Conference Manager, Informaction, Addiction Research Foundation, 33 Russell Street, Toronto, CANADA, M5S 2S1**

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Cheque enclosed **Please invoice me**

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Your signature on this form indicates that you accept the conditions for Registration and the cancellation clause.

Inflation, terrorism, unemployment and British keep on drinking

By Harvey McConnell

HE'S THERE every night. Just inside the entrance to Henekey's, a large pub on the corner of Leicester Square in London.

The uniform is close enough in color and cut to that worn by the familiar "bobby" for you to know he means what he says.

"Excuse me, sir. Can I check your bag please?" . . . and coat and trousers and pocketbook.

The security check is carried out on customers entering most pubs, restaurants, and movie houses in the West End of London these days. And it's just one more manifestation, albeit the only sinister one, of the crisis in Britain's once booming drinking and dining businesses.

From a medium-sized pub run by an expatriate Canadian at Brighton on the English Channel, to a cavernous pub in Edinburgh, the refrain is the same: Business is bad and we are just holding our own.

Sales of Scotch and other liquors are down markedly. Major breweries have seen their profits slip nearly 10% over the past year.

Rampant inflation and rising unemployment started to take a toll 18 months ago. But it was the staggering increase in taxes on wine and liquor brought in by the Labor Party government in April, 1975, that rocketed overnight the cost of having a drink in Britain, be it in a pub or at home.

Direct price comparisons for the North American do not seem, on the surface, too onerous: Liquor costs between .55 and .60 cents a drink (although the measure equals only half a jigger), and a pint of beer is a few cents cheaper. All liquor costs around $7 a bottle in stores.

However, when the average earning ratio is considered—salaries here are roughly half their North American counterparts—then a visit to the pub costs a dollar a drink for liquor or a pint, and a bottle of Scotch or gin works out to $14.

Smokers suffer as well—on the same scale, king size cigarettes work out at $1.80 a pack.

Even drug users are having a rough time. Scotland Yard's drug squad recently made its biggest haul ever of cannabis—1,700 pounds and worth nearly $1.5M on the streets. Intense police activity has for several years kept cannabis at $30 plus an ounce.

Restaurants, like pubs; feel the economic pinch. A survey of 150 top restaurants around the country by one of the good food guide organizations has found diners now choose less expensive wines with their meals. And few of them now end with an after-dinner brandy and cigar.

People are eating out less often as well. In their turn, restaurants, which claim running costs have risen an average 30% in 1975, now present less expensive menus.

All is not gloom and doom, however. Pubs are still the convivial place to meet and Britons are still drinking although more often now at home. More and more people, especially the young, are plunking for "plonk," the slang for inexpensive blended wines.

Plonk has become so popular that Allied Breweries is selling off at auction soon, a large selection of fine wines. It claims it needs the money to buy more plonk, mainly from Spain, Italy, Eastern Europe, and more and more from West Germany.

There is a booming sale of equipment for home brewing of beer and even more of concentrates for making wine.

Now, instead of offering guests Scotch or gin, hosts turn to Sherry, vermouth and other fortified wines, and these are all up in sales.

The hardest economic blow has been to Scotch distillers. Even in London, where tourists replace some of the buying power, pubs report a drop in sales. Outside the capital, the slide is even steeper.

Scotch distillers never reveal sales figures but an expert observer of the trade told **The Journal**: "There is no question sales are down here and abroad. With the exception of the West German market, exports to other parts of the world, including Canada and America, have slumped.

"It is pure economics. Scotch is a luxury and in an economically trying time people push back luxuries.

"The truth is that distillers are businessmen and for years they have had it rather nicely. Price has been pretty stable for a decade and it came as a blow to them last year when the Chancellor of the Exchequer slapped on his heavy tax increases."

In the West End of London, the sight of security guards frisking patrons outside pubs and restaurants is relatively common now. Britons, fearing terrorists, and with less and less money to spend, are turning to home brew and "plonk"—inexpensive wines. However, pubs remain a way of life that will never die, writes Harvey McConnell from the United Kingdom.

Scotland's largest cooperage firm has decided to close a major factory in Paisley and concentrate barrel-making in a more modern factory. "But this would never have happened unless business was down," the observer added.

More bonded warehouses are under construction, indicating distillers plan a long storage period for millions of gallons of Scotch. They do not pay tax until it is bottled.

The observer said: "While the picture seems grim it looks as though the slump may bottom out by the end of the year. Certainly, many firms seem to be anticipating an upswing and I think you have to be careful not to paint too gloomy a picture."

To the Scot, who drinks more and smokes more than anyone in Britain, Scotch is not just a drink but *aqua vita*, a part of his heritage. Even the measures are larger in Scotland. But even the Scots have cut down.

The manager of a pub in the centre of Edinburgh said: "In midweek we are half empty. Business is still good on Friday and Saturday nights but, overall, business is not what it was two years ago."

Lorne Trottier, a native of Ottawa, settled down to run a pub with his English wife Valerie after ending a long career in hockey. His experience at The Sussex Yeoman, Brighton, Sussex, is typical:

"I have been 10 years in this business and this is the worst January, February, and March that I have experienced.

"I know my trade and instead of a regular coming in three times a week he may now come in only once this week and twice the next. Even the workmen who come into the public bar don't spend as much money on beer as they used to because they don't have it.

"This pattern is general among my friends in the business. They all complain about the same things."

Mr Trottier and his customers are lucky in one major respect at the moment—they do not have the constant fear of a bomb exploding nearby without warning. This added dimension has emptied pubs and restaurants in London more than might have been expected.

Capture of four Irish terrorists just before Christmas brought a lull over the holidays but in February the campaign of mindless violence began again.

Alan Burns is science correspondent of the Sunday Mirror and has also had first hand experience in covering bomb explosions. He lives in central London and feels the constant threat. He also sees the results.

"I went to the theatre recently, and although it was a popular show it was three-quarters empty. Tragic. Afterwards, as it was a lovely evening and as I never bring my car into the West End, we decided to walk down to Regent Street and look in the shops.

"You notice how empty the restaurants are and that nobody sits near a window. But it was not until we reached Piccadilly that I thought suddenly: 'My God! What are we doing here? If there is a prime area for bombs this is it.'

"The streets were empty, something I had never seen before and most of the people one did see did not speak English. I thought this is enough and we caught a cab straight home."

Mr Burns adds: "There is no doubt about it—people just don't have the money and they are also scared."

The security man at Henekey's in Leicester Square is friendly and efficient. A former prison guard now working for a private security firm, he has served in Northern Ireland.

His job is to inspect bags, parcels, pocketbooks, jackets, coats, trouser legs—"anything that could possibly hold a concealed weapon or bomb. And in this area we have a very bad incidence of drugs so we are trying to cut down on drug takers coming into the pub."

Most people submit to search willingly. For those who are obstinate "as far as I am concerned they leave the premises". Henekey staff are ready to back him up.

The security officer points out: "You can get blasé and that is when people can get hurt. I don't think people will try to bring bombs through this door because they realize now we have a check. Instead they try to throw it through a window (the pub has shatterproof glass) or leave it in a car.

"When a bomb does go off in London then trade goes way down here for three or four days before it starts to come up again." On a recent weekend, however, "by nine o'clock this place was dead".

Although there is no security man on the door of the Marquis of Anglesea opposite the Royal Opera House in Covent Garden, the staff are very security-conscious.

The feeling is contagious. My black shoulder bag holding tape recorder, camera, flash and other equipment is always kept in full view when visiting pubs or restaurants.

Assistant manager Ralph Johnson said: "We will keep an eye on your bag, not on you. But if you were to walk away from your bag we would ask you to pick it up and take it with you."

What is saving many liquor stores from crashing is the boom in wine sales which topped 500 million bottles in 1975, although overall consumption went down 7%, according to Peter Noble of the Wine Development Board, which is geared to greater public education about wine.

Tax on wine last April rose by more than 50 cents a bottle and even the cheapest plonk costs close to $2 a bottle. The rise "was the biggest single increase in the recorded history of our centuries-old wine trade," Mr Noble adds.

However, "the habit of drinking wine is now firmly entrenched. Wine is part of the way of life for all sections of society in Britain".

Mike Dowd, manager of a branch of Peter Dominic's, a major chain store, has plonk to thank for most of his sales. All liquor sales are down "but our wine sales are up about 20%, including the fortified wines".

What has suffered for Mr Dowd are sales of fine wines. "They are almost negligible. In fact, we keep them on the top shelf here now. Two years ago we sold a lot more."

Lovers of fine wine need not worry, however, even if they have to go out of their way to find the classics. Merchants like Tommy Atkins have increased sales by more than 40% in the teeth of the crisis.

His firm of F. & J. Turnbull in Hove, Sussex (100 years old in 1977) is a mecca for wine lovers and writers. The unpretentious, small counter with shelves of bottles belies the fact that in the cellars below are tens of thousands of bottles of fine wine.

Mr Atkins, a partner there for 51 years, said: "The potential for the wine trade in this country is, I am sorry to say, in plonk. There will always be a demand for fine wine but I can't see it growing.

"Our type of business is getting scarcer and scarcer. People have to travel to find someone like us."

Although the picture in Britain is gloomy, not even the most pessimistic observer thinks that drinking patterns will be revolutionized.

As Mr Trottier observes: "Pubs are a way of life in Britain. They will never die."

THE BACK PAGE

The Journal

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Dick Van Dyke

Guy Mitchell

Garry Moore

Mercedes McCambridge

Buzz Aldrin, Dana Andrews and Roland Barber

'I'm an alcoholic'

Celebrities 'stole the show' at the National Council on Alcoholism conference held in Washington DC. More than 50 noted men and women, all of them recovered alcoholics, faced reporters' questions. Story on Page 6. **Photos by Toby Barrett**

Saskatchewan takes lead drinking age goes up...

By Gary Seidler

REGINA, Sask. — Saskatchewan has maintained its reputation as an innovator in the area of health legislation by becoming the first jurisdiction in North America to raise the legal drinking age after lowering it previously.

The Saskatchewan Legislature voted last month to raise the province's legal drinking age to 19, effective September 1. (Saskatchewan lowered the drinking age, from 21 to 19, in May 1970 and again, from 19 to 18, in June 1972).

A private member's bill, proposed by Aubrey Pepper (NDP-Weyburn) passed remarkably quickly following a "free vote" in which opposition Liberals and Conservatives provided substantial support.

Like most other Canadian provinces, Saskatchewan has experienced growing teenage alcohol problems since lowering the age limit.

Traffic accidents and crime rates involving young people have increased and high school officials were reportedly anxious to keep alcohol out of the hands of students.

So this province at least, is prepared to live with a fundamental inconsistency . . . allowing 18-year-olds to marry, enter into contracts, or fight for their country but not to drink until they reach 19 years.

"This is an emotional and moralistic issue and it was treated that way," Doug Shattuck, acting director of Saskatchewan's AWARE program told **The Journal.**

"Obviously, our legislators are prepared to live with this inconsistency" (breaking the drinking age away from the Age of Majority).

Mr Shattuck said 54% of a 350 random household sample reported to an AWARE questionnaire that they favored raising the legal drinking age.

"This (the new law) is one of many things that can and should be done to reduce alcohol problems.

"Traditionally, there has been no input by health authorities in the liquor policies of this province," said Mr Shattuck, indicating a new optimism for the future.

In the legislature, Mr Pepper said there is no guarantee the new bill will solve the problem of excessive drinking by those 18 and below, but he argued it would be a useful step that would reflect concern about the problem and set an example.

Mr Pepper agreed with earlier critics who said responsibility cannot be legislated: "There are 15-year-olds who can use alcohol more responsibly than some 18-year-olds, just like there are some 18-year-olds who can handle this responsibility better than some 40-year-olds.

"I do not think we can say that because we cannot legislate responsibility, that gets us off the hook and we should just leave well enough alone."

Mr Pepper said the legislature should admit a mistake was made in 1972 when the drinking age was lowered to 18.

To support his argument that the reduction to 18 was a bad move, he said since 1972 the sale of liquor in the province

(See — Sask. — page 6)

...Ontario limit 'being considered'

TORONTO — Ontario's young drinkers will continue to bend elbows in taverns for awhile, but for how long is anybody's guess.

Although the provincial government's Youth and Alcohol Report was tabled April 20, no tangible results of its many recommendations — including raising the legal drinking age to 19 and issuing mandatory identification cards for all those 25 years of age and under — are yet evident.

Caroline McCracken, special assistant to MPP Terry Jones who prepared the report on behalf of the Youth Secretariat, said various aspects of the report are now being considered by cabinet. "But nothing tangible has happened, and we just don't know when anything is going to happen."

She said, however, that the recent action of the Saskatchewan government in raising the drinking age in the province, coupled with growing concern in other parts of Canada and the US to raise legal ages for consuming alcohol, will lend support to the Ontario situation.

Paraphrasing Ontario's Premier Bill Davis, Ms McCracken said: "It does indeed warrant very speedy action."

Canadian psychiatrist charges

Government manipulates health care

By Milan Korcok

MIAMI BEACH—The future of alcoholism treatment and research is more likely to be influenced by political and economic factors than by any rational appraisal of what is most appropriate for the greatest numbers, Dr Lionel Solursh of Toronto told the annual meeting of the American Psychiatric Association.

Citing Canada's experience with medicare, Dr Solursh painted a grim picture of government intervention and manipulation of health care—alcohol and drug treatment services included.

"Several years ago, the three political parties in Ontario agreed in committee to the production of a central data file of complete medical histories on the entire population of the province," charged Dr Solursh, associate professor of psychiatry at the University of Toronto.

"Think of the ramifications (of this kind of documentation) on alcoholism and drug treatment programs."

Computerization and storage of medical information on private citizens is very much a part of Canada's national health insurance system. This is something to be watched with the utmost vigilance by people in drug abuse treatment concerned with maintaining confidentiality of patient data, he said.

He also warned the conference of the delicacy of the link between government priorities and the funding of specific health programs.

Current cutbacks in health spending, dictated by governments, cannot help but influ-

(See — Political — page 3)

Full coverage of the annual meeting of the American Psychiatric Association, held in Miami Beach, will appear in *The Journal* next month.

New treatment cures addicts' cravings

BARCELONA, Spain — Ten long-term drug abusers have apparently been completely relieved of their craving for drugs by combination therapy with two narcotic antagonists — alpha methyl tara tyrocine and 5 butylticolinic, also called fusaric acid.

Disclosure was made here by Dr José Pozuelo, a Spanish-born Cleveland Clinic psychiatrist who has been treating the addicts at the University of Barcelona Hospital since March.

The treatment not only cured the addicts of their craving within 10 to 15 days, but eliminated withdrawal symptoms, he said.

The addicts had documented records for abusing cocaine, morphine, heroin, and amphetamines for from three to 17 years.

Cleveland Clinic physicians now hope to get permission to test the double drug therapy in the United States. They are applying to the National Center for Drug Abuse in Washington DC for that purpose.

• The Journal presents a pull-out section devoted to conferences this month. Reports from the International Conference on Alcoholism and Drug Dependence in Liverpool, the National Drug Abuse Conference in New York City, and the Federation of American Societies for Experimental Biology in San Francisco begin on Page 7.

Liverpool

New York

San Francisco

More Inside

Pilot project helps elderly drinkers

By Anne MacLennan

TORONTO—At least six per cent of the residents of old peoples' homes are probably problem drinkers, says Dr Sarah Saunders of the Addiction Research Foundation of Ontario.

Dr Saunders is the developer of a Toronto program believed to be the only one of its kind anywhere. Now in its third year, the program is aimed at reducing problem drinking and helping problem drinkers in a senior citizens' home.

In the first year of the program, of a total population of 480 residents, 29 (6.2%) were identified as problem drinkers — 23 males and six females. The figure has remained constant.

Dr Saunders says while problem drinking among the elderly is increasingly discussed, little research has yet been done and she has found no evidence of programs similar to hers. However, she speculates that between 6% and 20% of residents in homes for the elderly have problems with alcohol.

Although she claims her program is "still experimental", indications are that if staff treat problem drinkers with interest and encouragement, and if a wide variety of activities is available, the elderly problem drinker will become happier, more active, and less abusive and may also, almost incidentally, decrease alcohol consumption.

To those who might suggest it is cruel to remove what an elderly person may see as one of his or her last remaining pleasures, Dr Saunders has a two-fold reply:

Firstly, one assumption of the program is that alcohol represents something positive and should not be removed entirely. Rather, the aim is to help the problem drinker to improve the quality of his or her life and relationships to the point where alcohol is not seen as the ONLY form of pleasure.

Secondly, she says: "I have yet to see an alcoholic in a home who is happy. They look frightened... terribly uncomfortable. All you have to do is spend some time with them and you see they are very unhappy people."

When they get drunk? "They sometimes get angry or they sometimes just go to sleep. Sometimes they talk a little more but often when they do it's violent language that is coming out... or disruptive behavior."

Dr Saunders began the program after she was called in by the director of nurses at the home—then Lambert Lodge but now on new premises with a new name, Castleview-Wychwood Towers—to help sort out alcohol-related problems among residents.

"The most obvious difficulty was violent acting out, disruptive physical and verbal behavior. You could stand on the first floor and hear them on the fourth floor and wonder how anybody could cope," says Dr Saunders.

Common to all, were problems of loneliness and boredom and great difficulty forming relationships with fellow-residents. They tended to spend their time drinking, alone, or watching television — "in other words, almost totally isolated except for the interpersonal contact that occurred during the violence accompanying the drinking".

The program aimed to increase activity among problem drinkers but to mix them with others having difficulty adapting but not having problems with alcohol. It was felt, says Dr Saunders, that if alcoholics were singled out for treatment, they might have extreme difficulty integrating back into the residents' community after treatment.

Even now, there is no "alcoholism treatment program" as such. Weekly group meetings and other activities include both problem drinkers and other residents.

Early on, says Dr Saunders, it also became "blatantly clear" that a full time staff member was needed to coordinate the program; to provide the personal contact and encouragement necessary; and to help those involved develop an interest in increasing their activity.

That role was filled by Ms Anna Gushue, an "invaluable asset" whose absence on holidays is always immediately reflected in increased drinking and behavioral problems.

Ms Gushue admits life was sometimes "more exciting" before the progam began—"you never knew when you were going to get hit on the head by a flying ashtray"—but enthuses over the effects of the program on residents.

Of 21 alcoholics monitored on a daily basis in the program's second year, 12 showed varying degrees of improvement. Of those, 10 increased activity and involvement and decreased drinking and associated abnormal behavior; one showed increased activity and involvement and behavior although no decrease in alcohol consumption; and one showed no increase in activity but a decrease in drinking.

Says Dr Saunders: "The key to the potential effectiveness of this progam is intensive interpersonal staff/resident involvement. Without this, the program fails. The maximum staff/resident ratio would seem to be in the area of 1/15 to 1/20."

Elderly problem drinkers need more attention

Soon to be No. 3 killer

Cirrhosis is striking earlier

TORONTO — Cirrhosis of the liver is killing more Canadians at a younger age than it did 25 years ago, according to Dr Wolfgang Schmidt of the Addiction Research Foundation.

Dr Schmidt, speaking here to an International Symposium on Alcohol and the Liver, sponsored by the Canadian Hepatic Foundation, also said that by 1985 liver cirrhosis will jump from the fifth to the third leading cause of death in men aged 25 to 64 (following heart disease and cancer).

The biggest jump in the incidence of deaths caused by the disease was among men between the ages of 35 to 49 during the years between 1950 and 1972. Consequently, said Dr Schmidt, the mean age of death decreased to 57 from over 60.

In 1974, he said, there were fewer than five cirrhosis deaths for every 1,000 deaths from all causes in Ontario's male adult population. By 1973, this figure had risen to 22.

In 1945, among men between 40 and 49 years of age, there was one cirrhosis death for every 115 deaths from other causes. In 1972, one out of 18 deaths had been attributed to cirrhosis, said Dr Schmidt.

In Canada in recent years, cirrhosis has been the most rapidly increasing cause of death among those over 25 years of age, followed by cancer of the lung and suicide.

Among women, the increase of cirrhosis deaths has been slightly less — from 3.34 to 13.05 in every 1,000 deaths from all causes between 1944 and 1973.

Dr Schmidt said the two causes of death which have risen most rapidly — lung cancer and cirrhosis — are potentially the most preventable since they are linked with behavior, which Dr Schmidt termed "self-indulgent".

The increase in general mortality among middle-aged men, in contrast to improving mortality rates among other segments of the population, is linked with the rapid increase in diseases related to alcohol and tobacco "which have affected men of this age range more than any other group," he said.

Reduction in over-all consumption (as during the two world wars), is followed by a drop in cirrhosis deaths. Drinking trends, Dr Schmidt outlined, can be related to personal disposable income; cost of alcohol relative to income; and trends in beverage preference.

Prophets play catch-up while critics confer

By Wayne Howell

IN THE BIOLOGICAL sciences, the prophet always has the upper hand. First he asserts that his panacea will work and offers his statistics to prove it. Immediately, research institutions start to test the findings and in due time they produce a report saying they are unable to duplicate the findings. The prophet can now play his first ace — the institutions didn't use a high enough dose: the prophet is getting wonderful results with double the original dose and no side effects recorded.

The institutions start again, shaking their heads and feeding their test subjects the higher doses. Still no discernible effect. Well what can you expect, says the prophet, laying down another card the test doses were too small: if they would only use the same dose as the prophet is now using - quadruple the original then they too could get statistically significant data.

And so it goes. So it has gone with vitamin C for colds and vitamin B for schizophrenia and mental ills various. And by the time side effects from massive doses start to rear their ugly heads, the fad has pretty well worn itself down anyway the combined weight of schizophrenics being re-admitted to hospitals approaches the combined weight of B complex vitamins being dispensed allegedly to keep them out. And enough persons eating daily the vitamin C equivalent of Anita Bryant's weight in oranges have come down with enough mid-winter sniffles to somewhat dampen their enthusiasm.

But in the 'social' sciences it is the critics, not the prophets, who have the upper hand because they can assail an innovation at any point in time by introducing any number of new (or old) concepts which, by their definitions, are critical.

Methadone maintenance programs, for instance, have been attacked by a group of doctors from New York's Rockefeller University writing in the The Journal of the American Medical Association because the programs have failed to give the clients 'self-respect' along with their methadone. (That's right they clean forgot about that ol' self-respect. Which everybody gotta have. They clean forgot to dish that out too.)

It matters little that self-respect cannot be ladled out like methadone, that it cannot be engendered instantaneously in the heart of a person who has lived his whole life without it because his mother ignored him and his father beat him, his teacher resented him and his peers disparaged him, and society dumped on him whenever it got the chance.

It matters little that perhaps the only way one could achieve that goal would be to arrange for everyone to be born into a genetically sound, stable, middle class family that would provide the requisite amounts of parental love and affection, understanding and encouragement, as well as the maximum number of educational, cultural, and social advantages. (That would pretty well wipe out heroin addiction but it is a hard trick to pull off.)

It matters little that if one can in fact inculcate self-respect as late as the second or third decade of life, it is a little easier to do in someone who is spaced on methadone but not as far out as if he were on heroin.

And it matters little that methadone maintainers might respond that they were doing the best that they could in the self-respect line, given their budgets and the demands on their time. Because the critics will just play another card ego-strength, for instance. (Yup, that ol' ego-strength that everybody gotta have. Them dummies down in the methadone dispensary clean forgot to dish that out too). Or self-awareness. Or inner resources. Or some such thing.

And so, unlike our previous example, it is the prophets who are always playing catch-up ball. The most they can hope for is a seventh inning stretch while the critics take time out for a conference or two or three or more, to decide just which critical forgotten factor is the most critical of all.

(Wayne Howell is an Ottawa physician and freelance writer.)

Deposed chief is criticial of BC's new tack

Peter Stein

By Tim Padmore

VICTORIA, BC — Peter Stein, deposed head of the British Columbia Alcohol and Drug Commission, laughed and said: "Well, I guess I had something to say about them after all."

Mr Stein, who took a job here as a school counsellor following his firing in January by BC's new Social Credit government, had begun the interview with reservations ("I'm not used to thinking in broad, important terms these days . . .") but ended with sharp criticism of the new commission's move away from community involvement in initiating programs, its pre-occupation with heroin as opposed to alcohol, and its leaning toward compulsory treatment.

At the same time, he conceded many of his positions have a philosophical rather than a scientific basis.

In its three years under Mr Stein, the commission encouraged programs developed by local groups and tried to involve a variety of health professionals in drug dependency problems.

A new three-man commission under Bert Hoskin, former director of the Narcotics Addiction Foundation, plans to develop its own programs, ones reflecting Mr Hoskin's and health minister Bob McClelland's conservative approach to drug problems.

"I think a lot of good work leading to furthering understanding in the broader community may be going down the tube," said Mr Stein.

The centralized approach, he said, is likely to run into problems in getting its programs accepted in the community, in broadening professional willingness to deal with addiction, and in gaining the trust of drug addicts and alcoholics.

"However, most of the community is vastly apathetic about drug dependency. There won't be any difficulty in abandoning the notion of inviting a broad spectrum of the community.

"And I suppose it's a matter of conjecture whether this is really a bad thing."

What about Mr Hoskin's recent proposal that drug addicts who come before the courts and alcoholics in detox centres be subjected to compulsory treatment? And about the new chairman's advocacy, before his appointment, of registration, isolation, and compulsory treatment of "unco-operative" addicts?

Said Mr Stein: "I turn red about community involvement, but I turn purple over compulsory treatment."

He challenged the idea with a series of questions:

"If there's going to be compulsory treatment, the first question is, which drug? Alcohol is far out in front in terms of number of users and harm caused.

"Who would be the target? The chances are it would be the young and the poor. But it's the middle-class 30- to 50-year-old alcoholic who is doing the most damage.

"What will the treatment be in quarantine, beyond drying people out? They refer constantly to Japan, where apparently all they did was hold people for six months and let them out."

(In a recent interview Mr Hoskin cited a Japanese compulsory treatment program which allegedly reduced the number of addicts in that country from 40,000 to around 40. However, said Mr Stein, there was no individual follow-up, and, he suggested, some addicts might simply have changed dependency. Japan, he said, has a "horrendous" alcohol problem.)

He said New York has abandoned a compulsory system, moving to a criminal model, and recalled the failure of an experiment at the federal prison at Matsqui, BC.

Studies showed that graduates of the Matsqui compulosry treatment program later used more drugs and committed more crimes than control prisoners although they were judged to be "more together".

"And finally," he asked, "who is going to pick them up? The police are very unhappy about being in the picture now. And who is going to work in the treatment centres? Social workers, doctors, and nurses hardly want to work in a voluntary setting; I don't see them flocking to a compulsory one."

He also warned that building special facilities for addicts would be very expensive, noting one estimate that a facility for 1,000 addicts would cost $25 million.

Mr Stein, 39, was a member of the Le Dain Commission for five years from 1969 to 1974 and before coming to the BC commission, was assistant director of the Alberta commission, worked with the Montreal Council of Social Agencies and the Company of Young Canadians, taught social work at the University of BC, was assistant director of the John Howard Society here, and served as a juvenile probation officer in Seattle.

'Political decisions shape health care system'

(continued from page 1)

ence the shape of alcoholism treatment. Already, almost all federal grants for health research (including alcoholism) have dried up . . . and a number of medical researchers have definite plans to leave the country, Dr Solursh warned.

This is not to say governments should not be involved in the financing of health care and the coordination of basic standards. But individuals and groups contemplating national health insurance ought to be aware that "you only get what you pay for, and burgeoning bureaucracies carry their own risks".

When control becomes so absolute, the shape of the health system is dictated by political decisions. This is particularly risky given government's tendency to cut back wherever there is least resistance.

What does this strengthening government control presage?

Solursh predicts a lessening of support for identification, detoxification, and treatment programs in favor of more punitive and legalistic initiatives.

"Over the medium range the cost to industry (of alcoholism) is sufficiently great that programs may evolve supporting early recognition, confrontation, support, and treatment. But much of this will be bureacratically determined on a theoretically cost efficient basis by the growing control of programs by governments.

"He who pays the piper calls the tune," said Solursh.

"Overall, I would expect the community's approach to remain essentially legalistic for some time. This would involve civil law responsibilities, punitive jail terms, higher taxation, and more restrictions on drinking (via age and availability control), rather than therapeutic, educational, or rehabilitative initiatives."

Mississippi treatment program

Alcoholics patients given two treatment goals

By Thomas Hill

JACKSON, Miss.—A new alcoholism treatment program here gives the patient a choice of two goals: He may learn how to stop drinking altogether or aim for "controlled drinking".

It's a cooperative program between the Veterans Administration Hospital in Jackson and the University of Mississippi Medical Center and is supervised by Dr David Foy, director of the VA alcohol treatment programs, and Dr Peter Miller, UMC associate professor of psychiatry.

"What's wrong with some treatment programs," says Dr Foy, "is that abstinence is so often the only goal. Just because a person hasn't had a drink in years doesn't mean the quality of his life has improved."

Dr Miller puts it this way: "Only about 60% of people with drinking problems have much success in abstinence programs. Obviously, traditional ways of treating alcoholism have little to offer the other 40%."

The idea of teaching alcohol abusers how to control their drinking is gaining acceptance across the nation because people are revising their views concerning the nature of alcoholism, the Mississippi psychologists contend.

The truth of the statement "once an alcoholic, always an alcoholic" is being challenged today, they say, because recent research has shown some alcoholics can, in fact, learn to control their drinking behavior.

"We don't teach social drinking," Dr Foy points out. "Many social drinkers misuse alcohol, although they may not drink often enough to create a major problem."

Counsellors in the program give patients basic information about alcohol use—how much liquor they may consume in an hour and stay sober, or how to refuse a drink when they know or suspect another will be "one too many".

Drinking skills are mastered in a series of 30-minute sessions in which only the counsellor and the patient participate. Role-playing sessions, videotaped so participants may observe their own behavior, help reinforce responses to social pressures they'll meet when they leave the program.

The counsellors also advise patients to plan their drinking activity before they go to a party.

"We tell them to drink slowly," says Dr Foy, "and to mix tall drinks so the amount of mix is much greater than the amount of liquor."

If a patient decides he never wants to drink again, the counsellors encourage this and direct their treatment accordingly.

In defence of the two-goal program, the psychologists point out that they are preparing their patients for re-entry into the social life of a nation in which 70% of the adult population drink liquor with some regularity.

A videotaped treatment centre. Standing, Dr Peter Miller, sitting, Dr David Foy.

Canada's drug use alarming

OTTAWA — Illicit drug use in Canada is rising at an alarming rate despite the millions of dollars poured into law enforcement.

Solicitor General Warren Allmand told the Commons justice committee recently that even more money will be spent in an attempt to thwart the spread of illicit drugs anticipated after the Olympic Games in Montreal in July.

Although the actual amount spent by the RCMP on drug enforcement is not clear, Mr Allmand told the committee the amount was substantial.

Police say drug-related crime has also resulted in ballooning costs for court cases and has also neccessitated the growth of municipal police forces throughout the country.

One estimate has put the cost of a major drug case to the taxpayer at more than $1,000 a day once it goes to court. At one point last year, there were 600 major cases in Vancouver alone.

In 1964, Canada recorded 564 drug offences. Ten years later, more than 59,000 people were in court on drug charges.

"The problem of abuse and trafficking continues to increase in alarming dimensions," Mr Allmand said. "It is no longer confined to illicit heroin or even marijuana."

Mr Allmand said the drug problem represented a major social concern, relating to thefts, physical violence, and murders.

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Integration an answer

WHEN ADAMHA was being set up, there was some hope that drug abuse and alcohol activities could finally achieve some sort of integration.

Alcohol would be seen as one of a number of drugs of abuse, and response to the sequellae of abuse could be broadened to reflect a "human services" base rather than a drug-specific one.

This has not happened, and there are no encouraging signs it will happen.

Already, many single state agencies have shifted into the "substance abuse" model. They see the rationale for integrating some of their alcohol and drug initiatives into more cohesive form. A good number have been pressing for the appropriate federal agencies to allow them to submit joint alcohol and drug abuse plans in respect to receiving state formula grants.

Municipalities as well as states across the country are recognizing more and more of an abuse cross-over with secondary alcohol use compounding an already difficult narcotic treatment regimen, and opiates or barbiturates adding to an alcoholic's agony.

Consequently there is good reason to look favorably at Rayburn Hesse's promotion of a Behavioural Health Services Administration (see page 9) to replace the existing ADAMHA structure.

His recommendation is to merge alcohol and drug activities (preventive as well as therapeutic) into a broader field which would also encompass mental health and dysfunctional behavior.

Perhaps the model he presents is not the ideal one, and further scrutiny may show it to have major deficiencies not at first apparent, but if it does nothing more than move the field toward some form of integration, it will have served its purpose.

In another speech to the National Drug Abuse Conference, Dr Marc Hertzman, formerly with NIAAA and now with HEW's National Center for Health Services Research, emphasized that workers in the field of alcohol and/or drug abuse have managed to isolate themselves from the main body of health specialists.

This kind of fragmentation at a time of intense financial stress makes the entire field exceedingly vulnerable. There are major issues to be confronted over the next few months and years, not the least of which is the prospect of national health insurance.

What will such insurance cover? What kind of exclusions will it make? What kinds of stipulations will it demand of the people providing service?

As Dr Hertzman said in his speech, if alcohol and drug abuse services are covered only in very restricted categories, treatment could be drastically curtailed.

It seems reasonable to hope that a cohesion of alcohol and drug interests, strengthened further by integration into a broader range of human services, would give the field a lot more clout in lobbying for certain advantages. It would have a lot more weight in pursuing consistent and stable financing policies out of Washington, and in influencing priorities to give prevention and training a better break.

Such cohesion might also allow a more rational approach to the training and credentialling of drug abuse personnel.

And perhaps most important, such action might provide a good deal more strength in combating those many societal conditions which contribute to abuse and to various other kinds of human dysfunction.

Report deserves action

AT TIME of writing, it has been six weeks since freshman parliamentarian Terry Jones delivered his Youth and Alcohol report to the Government of Ontario .

So far, there is little indication of what the various government ministries intend doing with the 32 recommendations which came forth.

Generally speaking, the report provides an excellent summation of the increasing problems created by youthful drinking. More importantly, it deals with several important issues not specifically concerned with teenage drinking but with increasing alcohol consumption as a whole.

The Youth and Alcohol report is deserving of immediate attention and action.

"Take one each of these and call the Addiction Clinic in the morning."

Letters to the Editor

More letters — page 12

'Filthy, ugly...'

Sir:

Congratulations on your article (**The Journal**, March), entitled "Filthy, ugly, smelling habit under UK fire", by Thomas Land. We wish this television material could reach the teenagers in the United States where the teenager who smokes is really doing the "in" thing.

My father died of emphysema you can only imagine the suffering, agony, and panic he endured desperately trying to breathe, yet having his life end by suffocating, gasping for the air he could not get into his ruined lungs. If only smokers could view the end results of smoking in the individuals who are dying of lung cancer, asthma, and emphysema, do you think they would listen to the warnings?

I am extremely allergic to tobacco smoke and have received hypodermic shots of tobacco smoke three times a week in an effort to decrease my sensitivity to it. I was also taught to administer my own shots of tobacco smoke. This I did for a year, but with very little effect as I was still in smoky surroundings. At that time, I was an employee of the State of Wyoming and even with a request for a medical transfer by two physicians and a recommendation by the Governor of the State, NO place could be found by the personnel commission in the state complex for a secretary with 10 years of experience.

Fortunately, I am now employed by the Mental Health Center: I can post my Thank You For Not Smoking sign in my office and people honor it and I can control the pollution of the air in my office.

My husband had a massive coronary and was given orders: "Never smoke again"! This he could not and would not do. He still smokes his two to three packs of cigarettes a day and has divorced me because of my allergy and his inability to stop smoking. This way, I am permitted to live by breathing smokeless air. My husband can now go ahead, without killing me, with his own self-destruction. Another statistic in the making.

Why won't people believe the statement on the packs of cigarettes: "WARNING: THE SURGEON GENERAL HAS DETERMINED THAT CIGARETTE SMOKING IS DANGEROUS TO YOUR HEALTH"?

Lorraine Hicks
Cheyenne, Wyoming

Magic touch

Sir:

While you have solicited response from your Ontario readers, I too would like to express my opinion of **The Journal**. Of all the publications I read daily on all related subjects, I find **The Journal** most informative. I fail to find tainted reporting but rather find all issues on drug/alcohol problems presented squarely so the readers might draw conclusions of pro and con.

To say the least, myself and my staff appreciate **The Journal** and find it rewarding and informative. The problems of drug/alcohol abuse do not vanish just because a person is arrested, jailed, tried, and incarcerated or probated. Unless we are able to deal with the problem, the product, CRIME, continues to result. Too frequently, the professionals - police, prosecutors, defence attornies, judges, and correction staff - rely heavily on the judicial process as a solution to the problem when in reality it only served to bring the individual offender to the professional's attention for treatment.

I am still in search of the judge who has the magic finger that when pointed at the

(continued on page 12)

Backgrounder

This is the second in a series of Backgrounders on the US National Training System and on federal-state relationships in the training of drug abuse workers

By Milan Korcok

IN THE next few months, the "New Federalism" is going to have a chance to work its mystique on the people and institutions involved in drug abuse manpower training.

The shift is on . . . as National Institute of Drug Abuse policy defines it: "A maximum possible transfer of responsibilities and resources from the federal government to the states."

As of July 1, NIDA's three Regional Resource Centers and five Regional Training Centers will be reorganized so as to provide five regional support training centres. The new centres will then pick up on a mandate to move their training programs out of the tower and into the field, where the states say they want them.

Actually the shift has been going on for some time, but with the RRC-RTC consolidation, it becomes more tangible.

Just a little more than a year ago, the National Institute for Drug Programs (NIDP) handed out the last of its A.A. degrees to 92 graduates at the Webster College campus in Northwest Washington, DC. Until then, the NIDP had been bringing paraprofessional drug abuse workers to Washington from across the country to be trained in management and supervisory skills.

But NIDP was succeeded by the Career Development Center, an integral part of the evolving National Training System. And the CDC changed the emphasis of paraprofessional training by acting as a broker in the development of appropriate training facilities at existing universities and colleges—where the trainees worked.

In essence this is what New Federalism is all about — the decentralization of authority.

Recently, the National Association of State Drug Abuse Program Coordinators took a run at NIDA's national training system, especially the regional linkage that connects DC to the states. NASDAPC canvassed its members about the pros and cons of the system.

Results showed the great majority of states wanted drastic changes, ones that would give the states a lot more clout in determining training course content and its application. They wanted training to be more relevant to changing regional needs. They wanted more stress on individual state priorities and less dependence on pre-packaged, centrally-developed training manuals.

Of the National Drug Abuse Center (which serves as the hub of the national training system) the states were wary. Only five wanted NDAC training functions to stay as they were. All the others wanted changes, some of them abolition of the centre itself.

Of the five Regional Training Centers (New Haven, Miami, Chicago, Berkeley, and Norman, Oklahoma) only five states wanted them to continue unchanged. Fourteen states wanted them done away with, 10 wanted major modifications, and eight wanted them merged with the RRCs.

There was similar breakdown in response to the Regional Resource Centers.

Fortunately, the survey results didn't come as a great surprise to NIDA, particularly Dr Lonnie Mitchell, chief of the manpower training branch.

"Many of the recommendations made in the NASDAPC evaluation were ones we had already developed. In a sense it was good to see them reinforced by the states," says Dr Mitchell.

In the transition from federal to state training emphasis, the five Regional Training Centers seemed to occupy the most vulnerable positions. They knew funding was sinking, they knew NIDA was moving certain functions to the states and, being out in the field, they were painfully aware that state training personnel (as few of them as there were) didn't always know what the RTCs or the training system were all about.

How could they? State training officers could not be characterized by their longevity on the job. Between December 1974 and Deeember '75, 26% of state training officers (those given specific training liaison responsibilities) were turned over in their jobs, and they could only boast an average time on the job of 10 months.

Funding for these individuals came via the State Training Support Program (STSP) bankrolled by NIDA. But in the fiscal year '75, only four states—Arkansas, Idaho, Indiana, and Maryland, had committed all their STSP federal training money. Some hadn't spent a dollar of it.

Between the feds and the state training people stood the RTCs, sometimes suffering identity crises.

Dr Thomas Cahill, director of the RTC at the University of Miami, grunts and growls when somebody mistakenly refers to him as a NIDA employee. He is certainly not a "fed," says Dr Cahill.

He works for the Applied Social Sciences section of the University of Miami and is an associate professor of psychiatry. The RTC is a contract program negotiated between NIDA and the University.

The structure is similar at all five RTCs. They each have a primarily regional function although over the years each has refined certain areas of expertise. Thus, each continues to draw large numbers of its students from outside its own circumscribed region.

Miami and Chicago centres have a slightly higher percentage of trainees with backgrounds in education.

Berkeley and Yale have slightly higher populations of counsellors and therapists. Oklahoma and Chicago have serviced the greater proportions of vocational rehabilitation trainees.

Berkeley and Oklahoma account for the majority of native American trainees, Chicago and Yale for the majority of Black trainees, and Miami services the majority of Spanish-speaking populations.

A couple of months ago, before Congress restored NIDA's manpower and training budget to the $10 million level, up from the $3 million requested by the President, Dr Cahill was somewhat downcast.

He knew the forecast was not good, that the RTCs were under criticism, and that his own staff (already decimated by budget cuts over the past couple of years) was anything but confident about the future.

As NIDA's director of the division of resource development at the time, Dr Stuart Nightingale, had noted: If the $3 million budget holds up, there go the RTCs.

Did Dr Cahill feel there would be a last minute reprieve?

"I really don't know. I've got a staff here, they've got houses, families, mortgage payments, ears, kids and schools. But what can I tell them? It's March, and June is just around the corner (June 22 was the termination date of existing RTC contracts) and I can't even say there will be a job."

Well, the budget was restored, and the RTCs were given another lease on life, albeit in a different, though expanded, form.

Dr Cahill is less anxious, not only because his staff will have jobs, but because the regional link in the training continuum takes on new strength.

"That is a good move," says Dr Cahill of the RRC, RTC consolidation.

"If you eliminate the regional link, and the regional training centre, what do you have left?

"Ask that question and nine times out of 10 somebody will say—the states."

But Dr Cahill doesn't believe the states can do it, not right now, not without drawing on each other's expertise and experiences, not without a lot of cross fertilization between the states which have and those which have not. And certainly not without a pretty hefty federal presence in the way of technical and support roles.

At NIDA they call the technieal and support effort "capability building". This means getting the state training mechanisms to the point they can fend for themselves, given the support of federally produced materials.

If they use federal support and funding to get these mechanisms into shape, then a continuing federal presence won't always be necessary. At least, that's the way the conventional logic runs.

Dr Stuart Nightingale, puts it this way: "If I was in one of the states, I would like to get a good in-house capability to do the training, and use some of the state eolleges for that purpose.

"I would milk NIDA for what I could get right now in order to build up something good.

"I think the states are realizing that the future of training may not be all that good in terms of funding and we want to encourage them to act now—to build up their capacity now."

Next month: Who are the trainees? What are they being taught?

Inside Science

Reginald Smart is associate research director (Evaluation Studies Department) of the Addiction Research Foundation of Ontario

IT IS ALWAYS interesting to know whether psychological or physical problems will get better without any treatment. Usually, we feel that they will not.

Large and expensive treatment facilities are built with the expectation that such psychological problems as neurosis, alcoholism, and drug addiction will not often cure themselves. Although it used to be claimed that 70% or more of neurotics got better without any treatment, lately more careful studies have shown this figure is too high.

Recently, I made a review of studies of spontaneous recovery in alcoholics, including some seen at detoxification centres in Ontario. By "spontaneous" recovery I mean the recovery of an alcoholic to sobriety or controlled drinking without professional or trained therapists. I do not mean the recovery happened "mysteriously" or for no reason at all.

Spontaneous recovery might occur because alcoholics get help from friends or relatives or because something else in their lives led them to stop drinking. A serious illness or a friend's or relative's death might also somehow lead them to stop drinking.

There has been a number of studies showing alcoholism and other drug use problems disappear with age. The concept of "maturing out" has been recognized for a long time. There are very few old drug addicts—that is, addicts in their 60s and 70s. Some of them die, of course, but a number just seem to stop using drugs.

The same phenomenon has been noticed with alcoholics and problem drinkers. Studies of problem drinkers in the general population show most of them are young. In the American drinking practices study, 15% of males and 4% of females had high scores on a problem drinking scale. About 25% of males aged 21 to 29, but only 13% of those aged 50 to 59, and 1% of those aged 70 and over had problem drinking scores.

Many studies have been made of spontaneous recovery in alcoholics who have come to treatment centres. Some of these were not offered treatment or were offered it but did not accept. When followed up later, some were found to be abstinent but without any treatment.

For example, a six-month follow-up study by Dr Helen Annis (also of the ARF) and I of people admitted to detoxification centres showed 21% had no detox admissions or public drunkeness records and received no treatment for alcoholism beyond their detoxification.

One of the most interesting studies on spontaneous recovery is by Kendall and Staton (1965). They did their study at the Maudsley Hospital in London. It included 62 alcoholics referred for treatment but not receiving it. The alcoholics were followed-up for a period of from two to 13 years, with 6.7 years being the average period. Of the 57 actually found, nine were abstinent for at least 12 months, only one without treatment elsewhere. An additional 14 continued drinking with social stability—all without treatment. We could look at it another way: Of the 32 receiving no treatment at all, exactly half were abstinent.

When Kendall and Staton compared their results with a treated group at the same hospital there was not much difference. They concluded that treatment of alcoholics, including treatment with psychotherapy and drugs, enabled a small number of patients (not more than 10%) who would not otherwise have done so to achieve abstinence.

Some other studies of spontaneous recovery have indicated the reasons why alcoholics might recover without treatment.

Most of those who do, seem to have had some major change in health—especially a deterioration requiring sobriety. Others have had improvements in jobs, new marriages, or changes of residence.

Of course, these might be the very reasons (except for a deterioration in health) why alcoholics in treatment also recover. Those who get better as a result of treatment usually also have an improvement in their social stability.

There are many questions still to be answered about spontaneous recovery. We have very few studies with closely matched treated and untreated groups. Also, we are still not sure to what extent "untreated" patients get informal help or advice from their friends or relatives or from places like Alcoholics Anonymous.

At present, it seems spontaneous recovery could account for almost, but not quite as many improvements among alcoholics as does treatment.

Reginald Smart

Celebrities 'upstage' conference

By Gary Seidler

WASHINGTON — "I'M AN ALCOHOLIC."

With that succinct opening remark, they stood up one by one to declare to the nation their personal struggle with the disease of alcoholism.

Among them were an astronaut, acclaimed actors and actresses, prominent politicians, an Indian chief, and a surgeon.

It was an extraordinary gathering of *recovered* alcoholics. They highlighted (and at the same time, upstaged) the National Council on Alcoholism Conference held here last month.

According to the organizers of "Operation Understanding", the event will do more to reduce the alcoholism stigma than anything ever attempted before.

Certainly, it made for a unique news conference.

Fifty-three noted men and women, arranged in alphabetical order and arrayed in three elevated tiers of seats, were in good humor as they faced reporters in the zoo-like staging of the huge hotel ballroom.

Astronaut Edwin E. (Buzz) Aldrin Jr., the second man to set foot on the moon, talked about his postflight period of alcoholism and depression.

Republican Wilbur Mills, who achieved notoriety in the scandal involving one Fanny Fox, briefly remarked on his bout with the bottle.

Indian chief, Sylvester J. Tinker, chief of the Osage nation, traced his own alcoholism partly to a divorce and costly alimony settlement.

Dr William W. Daniel, a New Jersey surgeon, quipped: "I've had fingers pointing at me for 15 years — either because I was drunk or because I was sober."

From the world of entertainment, Dick Van Dyke, Mercedes McCambridge, Dana Andrews, Garry Moore, Guy Mitchell and others took their turns at the podium for a few moments.

Many of the 53 luminaries were declaring their recovery from alcoholism for the first time.

Though a publicity stunt, the gathering of celebrities had what organizers viewed as a deeply serious aim.

In a prepared statement, NCA president John MacIver said: "Tonight, for the first time, (these notables) are standing together as recovered alcoholics to demonstrate that alcoholism is a treatable illness and presenting a united front to eliminate the stigma which is killing people needlessly."

MacIver said the NCA organized the function "to dispel once and for all the myth that alcoholism is something which does not happen to 'nice' people".

"This disease affects people from all walks of life," MacIver said. "There are an estimated 10 million alcoholics in the United States, less than 3% of whom are in a skid row situation. The balance comes from all walks of life."

Many walks of life were represented at the event.

From the world of sports, baseball stars Don Newcombe and Ryne Duren, and basketball hall of fame winner, Edward "Moose" Krause, declared their alcoholism.

From political circles were former US Senator Harold Hughes and, from England, The Earl of Kimberley, a member of Britain's House of Lords.

Also, there were clergymen, labor leaders, journalists, authors, movie producers, physicians, military men, and business leaders.

On a couple of questions, the eminent group appeared unanimous.

They agreed they hate to be called "reformed" alcoholics. The term, said Dr Luther Cloud, NCA vice-chairman, implies erroneously that alcoholism is a moral straying rather than an illness.

And they agreed, through laughter and a quick vote, that alcoholism cannot be successfully treated through controlled drinking.

Only complete abstinence will stem the chronic disease's progressively damaging medical effects, officials said.

Marty Mann, who founded the NCA, rose to remind the audience that for women, alcoholism poses special problems.

She argued that society views women alcoholics twice as harshly as it does their male counterparts. "The stigma (for women) is still twice as great," she said.

When all was said and done, one was inclined to go along with John MacIver's conviction:

"We view this as a turning point in NCA's 30-year campaign to remove the stigma attached to alcoholism. It is an historic occasion for us."

Sask. has several reasons

(continued from page 1)

has increased, the estimated cost of alcoholism in the province in 1973 rose to close to $28 million, and statistics indicate a high percentage of accidents are alcohol-related.

He called on the government to set aside money to study the seriousness of the problem and he suggested anti-alcohol education should be part of the school curriculum.

Don Faris, an outspoken government critic of alcohol policies in the province, gave several reasons for the government's decision:

- Growing public concern based on observation of increasing problems in homes and communities;
- Mass media exposure of research results from Ontario on the effects of lowering the drinking age in that province;
- A small group of committed politicians in all three parties who would not let the issue drop;
- The focus on public concern through the AWARE program;
- The effectiveness of an inter-denomination letter-writing campaign. Mr Faris quoted: one cabinet minister as saying: "I expected letters from the United Church, but then I received them from Catholics and Anglicans too!"

One state is unconcerned, lower age not a problem

NEW JERSEY — At least one jurisdiction in North America appears relatively unconcerned about its teenage drinking problem.

When this state lowered its legal drinking age, from 21 to 18, in January 1973, opponents warned drunken driving by youths would create major hazards.

But, according to state police, statistics show that 18-to 20-year-old drivers account for just over 10% of all drunken-driving arrests in the state — 3,027 of 22,393 arrests last year.

"Nobody's concerned over that 10%," according to Lieut. Gordon Hector, public information director for the state police. "It's not the problem that might have been projected earlier."

San Francisco gears up for next NDAC

By Milan Korcok

TORONTO — Considering the agony and stress that goes with the staging of a national conference — particularly in the multivariate drug abuse field — it's a wonder anyone would accept the job of organizing such a "thing".

Even more bewildering is the fact there are volunteers standing in line. Not 48 hours after demonstrators disrupted sessions of the National Drug Abuse Conference in New York in March, representatives from Seattle, Portland, Detroit, San Francisco, Phoenix, and other spots, were nudging and shoving for the "honor" of doing it their way in their city in 1977.

The nod went to San Francisco, and to a committee headed by Dr David Smith, medical director of the Haight Ashbury Free Medical Clinic, president of Youth Projects Inc., Chairperson of the board of directors of the National Free Clinic Inc. — a man who doesn't need the recognition and surely doesn't need the workload.

David Smith

'We need a forum so we can bring conflicting viewpoints into the same context.'

But Smith is delighted to have the chance . . . to prove that national conferences, even in this day of sophisticated information processing, have a function of their own.

"In the drug abuse field we are all very emotional. We believe strongly in our respective positions. The scientist, for example, believes he is totally objective, yet he has a certain belief and value system that impacts on his own views. Everyone has his own particular view of the drug problem and everyone seems to think his view is the right view.

"We need a forum so we can bring these conflicting viewpoints into the same context."

Transmitting information from one specialist to another in the same field doesn't always require a national conference. But where "cross-fertilization" is a goal, and where it becomes critical to get individuals in one field to listen to others in another field, the national conference has some distinct advantages over monographs and audio tapes, says Dr Smith.

"The process used in pulling together a conference is critical," he says. "You can't do away with the professional or disciplinary compartments. But the people in these compartments have to be aware of each other and have to see they are all working at the same problem."

The San Francisco conference committee got off the mark quickly in defining a structure for the '77 meeting. The theme, a multicultural view of drug abuse, is going to demand integration of many diverse elements.

Dr Smith gives full credit to organizers of the New York conference for the substance and breadth of the presentations and panels. "The New York conference was tremendously diverse. I learned a lot about what is going on in many different parts of the country."

But he clearly does not want a rerun of demonstrations that deflect attention from the primary purposes of the sessions.

Many national conferences have become purely irrelevant or purely political, justified primarily by what goes on in the back rooms, says Dr Smith.

"The national conference has a special function and purpose that state or local conferences can not have. But, if it is not designed to allow that global view, or to integrate the diverse elements, then it is in danger of becoming irrelevant."

Dr Smith has already moved to reduce the risks of demonstrations by involving as many local programs as possible in the planning of the event. In effect, there shouldn't be enough groups left on the outside to mount any real disruption.

The multicultural theme of the conference is intended to open discussion on a wide range of subjects: Task forces representing the many different constituencies have already been set up — therapeutic communities, biomedical research, minority and cultural groups, women, methadone maintenance, state activities, and others.

Dr Smith has seen a renewed interest by state agencies in developing specialized presentations covering their concerns. As well, a task force has been set up to look at the problems of cities in drug abuse programming.

From a planning point of view it's an ambitious project, and Dr Smith is determined to lift it cleanly off the blueprint. But in doing so he will have to placate forces in other communities who felt snubbed by the site selection.

When San Francisco got the NDAC blessing to stage the '77 event, joy was not universal.

Immediately after the New York conference, Jim Fausel, chief of Arizona's Drug Abuse Program, circulated a memo to the NDAC's advisory and planning committee blasting the choice of San Francisco as a site.

"Many of those who attended New York's, Chicago's, and New Orleans' extravaganzas are tired of concrete and tall buildings, super-security measures, and $3 hamburgers.

"Those caught up in the work of the drug abuse industry need the wide open spaces to preserve some of the sanity which, in many instances, was missing in New York.

"Besides," and here Fausel fires his best shot "it is a heck of a lot cheaper (in the wide open spaces like Phoenix). I hope future choice selections will be based on economic considerations, not how powerful or strong the lobby is."

Mr Fausel has some good points in his memo, but, says Smith: "You don't sell a conference on cheap hamburgers and open spaces. You do it on your ability to hold a conference."

Dr Smith intends to hold a one-day session following the '77 conference to burn away any static that usually accompanies site selection.

"All the cities that want to host the NDAC conference should be prepared to make their case at this session," says Dr Smith.

"They should present their theme, their goals, describe their capacities in respect to hotels, meeting rooms, staffing. Putting on a conference is a very complicated thing. Those cities who still want to do it after looking at all these complications then ought to submit formal conference bids which would be openly voted on.

"I want Phoenix to support San Francisco, just as I will support Phoenix if it gets a bid in the future."

'The national conference has a special function and purpose that a state or local conference cannot have.'

International Conference on Alcoholism and Drug Dependence

Gary Seidler reports from Liverpool, England

Next move—tighter alcohol laws?

THE TREND of the past few years towards a relaxation of alcohol control policies may have reached rock bottom, according to an epidemiologist at the Addiction Research Foundation of Ontario.

Several recent surveys indicate a surprisingly large segment of the North American public would support legal restraints on alcohol availability, Jan de Lint told the conference.

"If there is indeed such a change in public sentiment, we need to be all the more concerned with the quality of the argument favoring legal restraints on alcohol availability," Mr De Lint said.

Since the relaxation of alcohol control policies has undoubtedly facilitated the proliferation of alcohol use and related problems, Mr De Lint said it would seem reasonable, in the context of public health, to attempt to stabilize trends and to control alcohol availability.

At the same time, he acknowledged a number of conditions exist which may impede implementation of such a control program. In other words, the quality of the argument for control policies can be much improved, according to Mr De Lint.

No matter how much evidence may be marshalled in support of legal restraints on alcohol availability, many studies have methodological shortcomings, he said.

He reminded his audience that many deaths and diseases in samples of excessive drinkers are largely attributable to their deviant lifestyle, smoking habits, neglect of proper nutrition, and unhappy states of mind, and not to their excessive use of alcohol.

"Therefore, it is difficult to predict whether the incidence of these deaths and diseases will at all be affected by restrictive control policies.

"On the other hand, if trends in consumption are not stabilized, rates of deaths from cirrhosis of the liver and from several other alcohol-sensitive causes will most certainly continue to climb."

A second impediment to the implementing of reactivating controls, said Mr De Lint, is the existence of popular notions about alcoholism which deny the etiological relevance of alcohol availability.

As an example, Mr De Lint pointed to the suggestion that heavy alcohol consumption by alcoholics is symptomatic of some particular disorder peculiar to them. The "alcoholism is a disease" theory is particularly favored by the alcohol beverage industry and is endorsed by many members of Alcoholics Anonymous.

"I have no doubt there are indeed significant individual differences in the likelihood of becoming an alcoholic, but it is well known that in exceedingly wet environments, where alcohol is readily available and frequently consumed, excessive drinking is a much more prevalent behavior.

"Restricting alcohol availability cannot prevent a very vulnerable person from becoming a heavy drinker but it can prevent less vulnerable persons from indulging."

Another example, Mr De Lint noted, is the suggestion that alcohol problems are rooted in the mysticism associated with alcohol use, in the ambivalent attitudes towards drinking.

Consequently, it is argued, young people should be introduced to alcohol at an early age so they may learn to drink moderately. Restrictive control measures are seen as reinforcers of an unhealthy ambivalence towards drinking and as impediments to the adoption of so-called healthy drinking styles.

In fact, Mr De Lint reminded the conference, the US Cooperative Commission on the Study of Alcoholism recommended several years ago that "drinking should become more 'civilized', e.g. the convivial use of beverage alcohol and drinking with meals should be encouraged, the so-called 'beverage of moderation' (beer) should be stressed, and drinking should become an incidental part of routine activities."

Mr De Lint commented:

"The rather naive idea behind this recommendation was that these so-called desirable drinking patterns would eventually replace so-called undesirable drinking patterns.

"Besides the logical flaws in the argument—why would vastly different consumption behaviors serving quite different purposes replace one another—there exists no evidence in the alcohol literature to substantiate this theory."

A third impediment to the implementing of alcohol controls is that such programs are perceived by many as a radical departure from existing preventive strategies, according to Mr De Lint.

UK drug laws: a sledgehammer effect

BRITAIN'S DRUG control laws, designed to minimize human misery, are having the opposite effect, says a prominent Scottish sociologist.

"We are using a sledge hammer to crack a nut," Dr Martin A. Plant, Royal Edinburgh Hospital, told the conference.

Rather than penalize a large number of people "who are not really a problem," Dr Plant suggested Britain review its drug situation and alter course.

"Would it not be more constructive to help the minority of drugtakers who need it than to waste police time and public money and to alienate thousands of young citizens by continuing with a witch hunt?" Dr. Plant asked.

In his paper, Is Illegal Drug Taking A Problem?, Dr Plant said penalties attached to many trivial drug offences are out of all proportion to the offences concerned.

The great majority are convicted of possessing small amounts of cannabis and are not drug addicts or large scale traffickers, said Dr Plant. He added:

"I believe our present drug laws were introduced in order to ward off an epidemic which never arrived."

Dr Plant suggested the so-called "British System" of managing drug addiction as a medical issue is now dead.

The system was established by the Rolleston Committee in 1933 at a time when there were relatively few addicts and drug abuse was not viewed as a social threat.

But since the Second World War, things have changed and, according to Dr Plant, Britain has built an elaborate system of drug controls covering a wide range of behaviors.

"Today, far more people are convicted of drug offences than are recorded as drug dependent."

Dr Plant claimed only a small number of those who use illegal drugs ever inject drugs or become dependent on them.

Most surveys, he said, show the great majority of those who use cannabis-type drugs are hostile to the use of opiates and other injected drugs.

"There is no inevitable escalation from cannabis to heroin any more than there is from the discovery of Smirnov to meths' drinking," Dr Plant added.

While he conceded there are problems associated with illegal drug taking—any psychoactive drug, legal or illegal, can be abused and most are—Dr Plant said that for the majority, cannabis and other drugs provide "an enjoyable facet of their leisure".

"Most young people are not unduly preoccupied with drugs, since they have other more pressing concerns and tend to be, at most, weekend hippies."

Those who do become drug casualties, either as offenders or patients, are very different from the majority of drug users, he said.

"Those whose drug taking is extreme and causes problems are invariably disturbed in many other ways. The drug scene provides a lifestyle which is free and easy, a haven for the eccentric, unhappy, or disturbed young person who cannot or will not conform to the demands of the mainstream of society.

Denial's not the prerogative of alcoholics

Few are aware of the stark reality

THE BRITISH have an international reputation for being the masters of understatement.

Nowhere is this more evident than in the government's official estimate of the number of alcoholics in the country, according to one of Britain's most experienced alcohol workers.

William Kenyon, executive director of the Merseyside Council on Alcoholism, suggested the denial aspect of alcoholism is not the sole prerogative of the alcoholic.

"The government, health authorities, and society in general deny the extent of the problem as it exists today and, moreover, it is reasonable to assume that few of any of these who have a responsibility for planning services to treat alcoholics have yet awakened to the stark reality of the situation as it is likely to be by 1980."

Official estimates put Britain's alcoholic population at 400,000. Mr Kenyon suggested the true figure is probably more than double this estimate.

Further, he predicted if the trend of the last decade is maintained, there could be one-and-a-half million alcoholics in the country by 1980.

Mr Kenyon berated national, regional, and local authorities for grossly inadequate action to deal with what he considers the "greatest single community problem that we as a nation face".

He compared Britain's meagre expenditures in the field of alcoholism (approximately $600,000 per year) to the $3,000 million spent to alleviate alcohol problems in the United States.

A study of trends over 10 years (1964-1974) showed alcohol consumption in Britain increased from 47.6 million gallons of absolute alcohol in 1964 to 70.2 million gallons in 1974.

Approximately two-thirds of Britain's alcohol intake is in the form of beer. Wine intake has more than doubled over the last 10 years.

The 10-year study also shows:—

- a 34% increase in convictions for drunkenness;
- a 368% increase in convictions for drunken driving;
- a 107% increase in alcohol-related admissions to psychiatric hospitals;
- a 49% increase in alcohol-related admissions to non-psychiatric hospitals.

Pull-out Section

Alcoholism: a new definition

WHAT IS alcoholism? A new definition has surfaced—this time from Dr D. L. Davies, medical director of the Alcohol Education Centre, London.

"Alcoholism can be defined as the intermittent or continual ingestion of alcohol leading to dependence or harm."

Dr Davies points out this definition cuts out drunkenness which is acute intoxication. It comprehends urge, compulsion, and craving and the alternative—actual withdrawal symptoms such as tremor—and harm. The harm may be physical, mental, or social in the broadest terms, that is to the individual or to others.

According to William Kenyon, executive director of the Merseyside Council on Alcoholism, the definition describes the least that all sufferers from alcoholism have in common.

Any one of the three features described, two of dependence and one of harm, is enough if it is a consequence of chronic ingestion.

National Drug Abuse C

Funding problems persist 'We want local help': Feds

AGAINST a backdrop of funding crises, relationships between federal, state, and local drug programming authorities grew increasingly tense as the conference wore on.

Though the wholesale slashing of New York State's budget held centre stage, participants from out of town could take little pleasure from their voyeurism.

As was stated over and over again at one blue ribbon panel presentation held in a jammed, hushed ballroom: "We've got problems."

"When New York cuts its services budget from $135 million to $78 million, we've got problems," said panel moderator Rayburn Hesse, executive director of the National Association of State Drug Abuse Program Coordinators (NASDAPC).

"When the state of California considers slashing its $70 million service budget by no less than 30% ... we've got problems."

And if the existing federal budget goes down as planned, 29 states will have less money to operate on than was planned for them at the start of the fiscal year, he said.

When NIDA chief Dr Robert DuPont spoke, he could do little to dispel the sense of gloom. Though federal treatment capacity for fiscal 1977 was being bumped up by 7,000 slots to 102,000 (from the 95,000 level at which it was maintained for a couple of years), Dr DuPont was not about to be cheered as a hero.

Many felt that even if the 7,000 slots were fully realized, they probably wouldn't be activated for some months, and by then the resurging heroin epidemic might wipe out all the gains.

(NASDAPC projected there are already 8,600 addicts waiting to get into treatment. And a report issued by the Drug Abuse Council concurrent to the meeting said treatment enrolment had already reached 98% of capacity on a national basis.

(The report also noted that if the use of Mexican heroin is as widespread as projections suggest, demand for treatment slots in the next two or three years could be sharply accelerated. It usually takes between two and three years before an individual who begins regular heroin use seeks treatment.)

Dr DuPont pulled no punches when he spoke of the changing responsibilities in funding of drug abuse services.

He assured the conference the federal government did not intend to get out of drug abuse treatment and prevention funding, but warned that states and communities would have to dig more deeply into their own pockets in the future.

"I urge you not to rely overly on the federal government in terms of your support.

"There is no possibility of the federal government assuming a great share of the responsibility that it already has," he said. And what that means is that if local programs are to grow there will have to be a much broader base of community support.

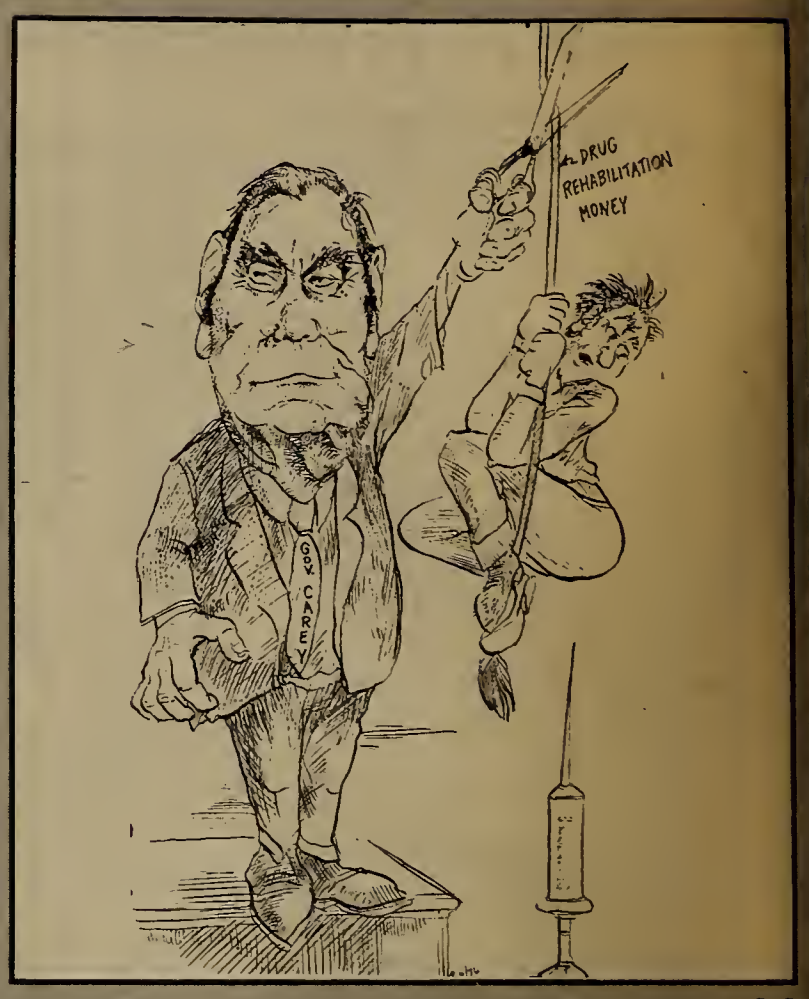
Dr DuPont said restraints in drug abuse programming do not differ from the restraints affecting many other kinds of social programs.

At the same time, however, he admitted to clear and growing evidence of very dramatic changes in the rates of drug use and drug problems.

He said that "between 1966 and 1975 there was a 10-fold increase in the United States in intravenous drug-related hepatitis. In 1967, 5% of college students reported they had used marijuana: last year it was up to 55%.

"Last year's senior high school class reported that 6.2% reported daily use of marijuana, and 6% reported daily use of alcohol.

"Marijuana is for the first time, passing alcohol in terms of high levels of consumption as recorded in a national sample."



Non-degreed staff need job options

THE PEOPLE who have contributed most to drug abuse treatment programming in minority communities face the most acute risks to their jobs and careers as the field becomes more sophisticated, political, and "professional".

Consequently, says William T. Marshall, head of a substance abuse training program in Los Angeles, a mechanism must be developed to allow non-degreed treatment staff to receive an appropriate credit for their skills and to have that credit universally recognized.

Many so-called "non-professionals" have in fact been functioning at a professional level, said Mr Marshall. These are people from a wide variety of backgrounds who have made their drug abuse treatment programs work.

They may not be credentialled, but they have good track records, especially with minority clients.

Mr Marshall said: "Many treatment program staff members do not hold academic degrees. A large number came to their jobs with years of street experience with drugs, and through their own treatment histories have become well acquainted with the treatment process.

"Many have worked in the field for years and have performed a wide variety of jobs."

The problem facing many of these workers, he said, is the reality that academic degrees often increase the likelihood of being hired in most occupation settings.

And though he suggested there is a lot of emphasis now on the process of credentialling drug abuse workers, such a credential does not carry the impact of a licence to practise or a college degree.

Consequently, it is important to develop a plan which makes it possible for the non-degreed treatment worker to receive a college degree and to build the flexibility into that training process to allow him to move into other fields.

Funding cutbacks in treatment are providing a threat to the field, he said. And people in this field should be made aware of their options in terms of career development.

"This is a critical issue since we must provide training for substance abuse professionals, but cannot ethically train them exclusively for jobs which may not exist in the future due to funding cutbacks."

He urged that funding sources for training development provide treatment staff with as many tools as possible for movement out of the drug area "as well as upward mobility within it".

In the course of this development some *rapprochement* with the academic community seems inevitable.

The concept of a "university without walls" or a degree which is awarded for equivalency credit based on life experience are both innovations within this area, he said.

"Working closely with local colleges and universities is another viable alternative to assure that credit can be received for training in knowledge and skill areas necessary to function as a substance abuse professional.

Marshall claimed it is the responsibility of the funding agencies to make sure adequate attention is paid to developing the creative and professional potential of many dedicated and talented individuals who work in the treatment of dependency disorders.

Psychiatrists have fluffed their role in subtance abuse: medical students

PSYCHIATRIC TREATMENT for substance abuse is a joke.

That "message" comes from a group of medical students at Georgetown University school of medicine in Washington, according to one of their professors, Dr Donald Davies, a psychiatrist.

"There is a long build-up of resentment about the role psychiatrists have been asked to play and haven't very well," Dr Davies said. And students aren't buying the concept of psychiatry for treatment of alcoholism.

In a panel discussion on alcoholism among physicians, Dr Davies and Dr William Flynn of Georgetown University Hospital, Washington, discussed special lectures they had held for medical students on the subject of alcoholism among doctors. Both reported great interest on the part of students.

Dr Flynn's students said a panel discussion in which five addicted doctors talked about their experiences, was "the best they'd had in medical school".

"I've have never seen students so involved by a panel in all my years. And you just don't get medical students to sit still for three hours."

He said now when he discusses patients with students, he uses physician patients as examples. "What we're beginning to get to is that our education has to be not only about patients but about ourselves.

"In the wind, there is a sense of optimism and also a sense of responsibility. For so long, there wasn't a sense of responsibility."

Alcoholism is a disease, it's killing people and if you aren't doing something about it, then you're not being a good physician."

Aged need social planning

PREVENTING SUBSTANCE abuse in the elderly is a social issue more than a psychiatric one, according to Dr Leon Salzman of Georgetown University medical school, Washington.

"The psychiatric treatment of addiction, limited to the treatment of the crisis and those psychological factors intrinsic to the aging process, is valuable and necessary.

"But, the solution will come from better social planning for the aging," he told a session on substance use in high risk populations.

Dr Salzman who has investigated substance abuse among middle-aged women, said that today the retirement years, instead of years of ease and quiet enjoyment, become a crisis period.

"For the man, retirement is frequently too early and he becomes a burden to his wife who finds him around as a constant nuisance.

In the "highly inflammable group called the middle class", he said, the drinking which has been moderate "now moves into abuse".

He said while he does not believe there is a special alcoholic predisposition, there is "certainly a kind of dependent personality - the compulsive individual—who easily becomes addicted. In the psychological sense, addiction is a compulsion.

"The middle-aged woman who becomes alcoholic is someone who has a predisposition in the sense of having been compulsive throughout her life - particularly the spinster because of her demand for perfection. She easily becomes the addict because of the presence of compulsive problems throughout her lifetime," he said.

Conference 1976:

More reports from New York by Milan Korcok and Anne MacLennan

Federal alcohol/drug activity

Sweeping changes urged by Hesse

A PROPOSAL to restructure radically the federal government's alcohol and drug abuse activities by integrating them into a comprehensive behavioral and social health services administration, was revealed at the conference.

Urging the sweeping changes, Rayburn Hesse, executive director of the National Association of State and Drug Abuse Program Coordinators (NASDAPC), said the existing system was too rigidly oriented along biomedical and physical health lines to allow adequate response to a broader range of dysfunctional problems.

"Our drug abuse and alcoholism, and mental health and social services systems are not designed to construct a stable, non-dysfunctional society. They are designed to salvage a minimum residue from the scrap heap of our social casualties."

Mr Hesse, who emphasized he was speaking as an individual and not necessarily on behalf of NASDAPC, said his proposal which is soon to be submitted to certain congressional leaders, calls first for the creation of a national commission that would study existing roles and relationships of organizations in the field.

This task force, modelled in part on the Marijuana Commission, would be charged with recommending new policies to federal, state, and local governments, and to components of the health and social services fields, concerning a behavioral approach to the problems of drug abuse, alcoholism, mental health and dysfunctional behavior, and related social problems.

Such recommendations, said Mr Hesse, should lead to the creation of a new behavioral and social health administration with HEW. It would assume the functions of National Institute on Drug Abuse, National Institute on Alcohol Abuse and Alcoholism, National Institute on Mental Health, as well as those of the Health Resources Administration, Health Services Administration, the Social and Rehabilitative Services Administration, the Office for Human Development, and "other HEW components which impact upon behavioral and social health problems".

In underscoring the need for this reorganization, he reflected on a federal bureaucracy which he said has been playing a defensive game in respect to drug abuse. Too high a proportion of the effort has been going to reduce the dysfunctional pool of narcotic addicts and too little to the prevention of addiction.

Federal bureaucracies have been virtually monopolized by a concern with narcotics trafficking, and treatment of narcotics addicts, he said. "Yet the majority of drug abusers in this country are non-narcotic drug abusers. Our treatment programming and our prevention programming to not reflect that knowledge.

Rayburn Hesse

"We need to commit ourselves to a policy of total, comprehensive, multiphasic programming. We must oppose the concept of programming which spurs competition between treatment and prevention and which isolates them as independent disciplines."

Mr Hesse emphasized merger of all service units is not a condition of his proposal. Nor is it essential that single state agencies merge alcohol and drug activities, although many have already done so.

Retention of a multimodality model is mandatory, he said.

"There must be intensive care units for the mentally ill. There should be therapeutic centres for heroin addicts, especially units that relate effectively to minority and cultural differences ... TC's should (try) to provide services other than counselling and treatment per se, but is is important to ensure that programs receive those clients with whom they have the highest potential for success.

It is not intended every program replicate the total range of social and health services, he said.

He hoped his proposal for creation of the behavioral and social health commission will bet a broad range of support not only from the states that form NASDAPC, but from program practitioners throughout the alcoholism, drug abuse, mental health, and social health fields.

There are critical issues to be resolved in these areas in coming months and years, he said—the necessity for stable, long term funding; program accreditation and licensing; personnel certification and credentialling; third party payments and national health insurance.

Important too is the establishment of a truly comprehensive primary prevention system.

"For too long, drug abuse prevention has been a step child. Prevention has too often been interpreted to me as education and information, with a consequent focus upon the schools as the primary deterrents, to the frequent exclusion of other aids and resources.

Resolution of such issues will be much more effective, he said, if they are placed within the context of a more unified behavioral health approach—"one that has the capacity to contain the multiple behavioral problems that confront this country".

Drug programs save city money

DRUG TREATMENT and rehabilitation is usually characterized as an expensive process, a steady drain on federal and state dollars.

But data released to the conference by Charles A. Lincoln, director of the Metropolitan Dade County Comprehensive Drug Program (CDP) shows cities have far more to gain, in terms of dollars and cents, by instituting a good service network than not.

"The (Dade county drug treatment) service delivery system employs approximately 500 highly-trained individuals," says Lincoln. "And this represents approximately $3.8 million in earnings to be spent within the county."

Without the CDP (a coordinative umbrella organization for 23 programs which lease 47 facilities) there would be a sharp increase in the cost of crime in the county, he says.

He estimates the average daily cost for a hard drug user to maintain his habit in Dade is $45. The CDP cares for just over 1,000 narcotic drug users per day. This treatment prevents approximately $47,250 in thefts and other illegal activities per day, and this amounts to $17 million per year in the county, says Mr. Lincoln.

The Dade County CDP is one of the nation's largest single, coordinated metropolitan treatment systems for drug users. Dade county is home to 1.5 million people in and around Miami.

All direct service treatment programs in Dade are encompassed by the CDP, except for the federally-operated Veterans Administration Hospital. The CDP includes a central intake service, emergency care and detox services, methadone maintenance programs, residential and outpatient treatment services, training and legal services, and a program evaluation mechanism. The 2,200 average daily client census accounts for almost 40% of all clients in treatment in licensed programs in Florida.

All drug treatment service dollars, whether they are federal, state, or county, are coordinated at the CDP level. Currently this amounts to $5.5 million.

Mr Lincoln says approximately 500 clients now need residential treatment services each day. If they were placed in hospital beds (which run at an average annual cost of $40,000) the cost to Dade would be roughly $20 million a year.

Good drug programming also offers economically sound options to existing penal institutions, says Mr Lincoln. The CDP annually offers 700 people charged with felonies and misdemeanours, options to jail. This saves the community money, says Mr Lincoln, as it costs $4,500 to keep an individual in jail for one year and only $2,800 to provide "positive client services".

The CDP also eases the overload in already-strained parole and probation departments and mental health centres.

Of the 8,000 drug abusers seen in the CDP yearly, most are arrested an average 1.4 times per year before treatment. Once in treatment, the arrest rate drops to 0.3% on average. This means a decrease of some 8,000 arrests per year, says Mr Lincoln.

CDP data drawn from February 1976 show 2,198 clients in treatment on any average day. Of these, 759 are in drug-free outpatient programs, 404 in drug-free resident programs, and 674 in outpatient maintenance programs. The rest are in various detoxification and day care programs.

In November, 1975, there were just over 2,000 clients in the system, and demand on the system continues to increase. Heroin addiction in Dade has increased approximately 16% in the past three months, says Mr Lincoln, and there is also a substantial rise in middle class addiction as it is reported in county emergency rooms.

In February, 1976, demand had outstripped normal capacity in many of Dade County's treatment programs. Hospital detoxification facilities were overloaded and working at 108% capacity. Outpatient detoxification slots were functioning at 243% capacity (an average daily load of 73 patients where normal capacity is 30).

Drug free resident programs were operating at 104% capacity, outpatient maintenance at 98%, and drug-free outpatient programs at 91%.

Without the CDP's coordinative function, and without having all the services tied into one multi-modality system, clients would go waiting, Mr Lincoln emphasizes.

More studies are needed on female drug abusers

FEMALE DRUG abusers are significantly more neurotic, less confident, and more guilty about sex than their male counterparts.

This is one conclusion following psychological assessment of 80 female and 246 male applicants for treatment of drug dependence at the Connecticut Mental Health Centre in New Haven. The research team was headed by Dr James C Ungerer of the Yale University school of medicine.

The researchers found female clients more maladjusted than normal groups in the general population; substantially more neurotic than so-called "normal" samples of females and males in the Eysenck Personality Inventory; and even more neurotic than Eysenck's "abnormal" samples.

With respect to achievement aspiration, women in treatment were substantially more cautious than previously reported collegiate samples.

As for guilt about sex, women in the study were more guilty than recent female and male college student samples. Male clients, however, closely resembled "normative" groups along all three psychological dimensions.

"The etiology of these differences is still a matter for speculation," says the team.

Federation of American Societies for Experimental Biology

Tim Padmore reports from San Francisco

Beagles unharmed by pot-smoking

TWELVE BEAGLE dogs smoked up to 13 marijuana cigarettes a day for a year-and-a-half without developing detectable ill effects, according to a report to the meeting.

Maurice Sullivan, staff scientist at Batelle, Pacific Northwestern Laboratories, who presented the results, said the animals were trained to inhale through a special mask designed to mimic human smoking.

Some of the dogs smoked cigarettes made from marijuana stems and free of the active drug, tetrahydrocannabinol, or THC.

"Our study was one of the few that have been done in which a normal smoking procedure was used and in which it was known for sure what the subjects were getting," he said in an interview.

Microscopic examination of autopsied tissues showed no pathological effects. Mr Sullivan said there was a "hint" of chromosomal abnormalities but there were too few animals to verify this.

He said a five- or 10-year study with a large number of dogs would be required to analyze properly long term effects, adding that the National Institute of Mental Health, which funded his project, is planning to support such a study using monkey smokers.

The beagles, which have been used in earlier studies on the long-term effects of cigarette smoking, "staggered about like drunks" at the end of a smoking day, he said. But, they appeared completely recovered each morning.

Other workers at the meeting, however, reported evidence that marijuana may cause subtle damage to humans.

Columbia University researcher G. G. Nahas reported further results in his studies of the effect of THC on cell growth. He finds that in high concentrations (.0001 molar) the drug prevents DNA synthesis in cell cultures.

Professor Nahas said similar doses of diazepam, a tranquillizer, and LSD had the same effect.

In experiments by Henry Esber, Harris Rosenkrantz, and Arthur Bogden at the Mason Research Institute in Worcester, Mass., rats given heavy does of THC, either orally or by inhalation, experienced decreased levels of testicular and thyroid hormones.

The results, they say, are further support for observations that marijuana can precipitate endocrine disorders.

THC has been proposed as a possibly useful drug for the treatment of high blood pressure and epilepsy.

However, pharmacologist Gerald Weiss of the University of New Mexico reported that the drug seemed to precipitate epileptic seizures when it was given to a colony of naturally epileptic dogs.

Social drinkers forget; alcoholics black out

THE FRIGHTENING blackouts suffered by many chronic alcoholics are just an exaggerated form of memory deficits experienced by every social drinker, says pharmacologist Jonathan Cowan.

Dr Cowan reached this conclusion after recent experiments testing the recall capabilities of volunteer drinkers.

Alcohol, he found, disrupts the organization of memory storage.

"Trying to retrieve something stored while you are sober is roughly analogous to trying to find a place, given an address but no map, in a city with a rectangular grid of streets. The grid and the street numbers help you out.

"In contrast, drinking alcohol during storage converts the mental landscape to something like the map of a hilly subdivision—many dead ends and streets running in every direction," he said in an interview.

In the experiment, 16 volunteer subjects at the University of California Medical Center in San Francisco consumed five Bloody Marys at two sessions. An equal number of controls drank tomato juice ("Virgin Marys").

Dr Cowan said the drinkers' immediate recall of a list of 20 men's first names was unaffected, but that at three minutes and 48 hours after learning, memory was decreased, indicating a blocking of "memory consolidation," the organization of remembered information in a retrievable form.

A second handicap of the drinkers was the occurence of "state-dependent learning".

"Experiences which occur while we are in one state of consciousness, such as when we are drunk, are remembered best when we return to that state," explained Dr Cowan, who manned a "poster session" display of his work during the conference.

"This . . . helps the drinker to forget his sober troubles, and the sober person to regret his drunken behavior less."

The pharmacologist said the mental and physical context of the experience reinforces this effect. Thus, providing retrieval cues restored the performance of the drinkers and incidentally verified that the information had not been irretrievably lost, merely misfiled.

The pattern of memory deficits, Dr Cowan said, is the same as for blackouts, suggesting an intimate connection. Immediate recall is unaffected, allowing the alcoholic to carry on a conversation while drunk, for example, and recall is aided by subsequent drinking, or by provision of clues. (In the experiment the clue was the name itself, presented as one item in a multiple choice list.)

He said these ideas can be used in treating problem drinkers.

"There are two extreme patterns for alcoholics. There's the binge drinker, who takes one or two or three drinks and loses control, and there's the continuous wine drinker, like the Italian or Frenchman."

Because the continuous drinker's "normal" memories and thought processes are associated with the drinking state, the correct therapy is gradually to decrease the dose of alcohol so those memories are not disrupted by a change of state, he said.

The binge drinker should, in principal, be switched off abruptly, but presents a tougher problem because something must be done also to relieve the build up of tension which leads to the triggering drink, said Dr Cowan.

He said study of the effect of alcohol on memory should improve the understanding of memory processes and perhaps will lead to therapy for the alcohol blackout and other memory problems of chronic alcohol abusers.

Jonathan Cowan

A few more pieces for drug puzzle

IT HAS been known for thousands of years that some drugs are harmful but the reasons why are only beginning to emerge.

Answers to some of these puzzles were offered by several researchers at the meeting.

Carl Becker and Theodore Dubin, pathologists at Cornell University Medical College, and Herbert Wiedemann, a Cornell medical student, told the meeting they have isolated and purified a chemical from tobacco leaves that they believe may be responsible for atherosclerosis and its related heart disease.

The substance is a small glycoprotein and the Cornell researchers found that when it was applied to the skin of volunteer subjects it often provoked an immediate allergic reaction.

They theorized that this tobacco antigen, since it is relatively small in size, passes easily from the lungs to the bloodstream where, reacting with antibodies, it causes localized injuries to blood vessels.

Platelets, cells involved in clotting, clump at the sites of the injuries, which leads to further changes culminating in the fatty deposits characterizing atherosclerosis, they suggested.

Jane Chin, Stanford University School of Medicine, described a novel technique for measuring changes in the "fluidity" of the walls of red blood cells in response to alcohol.

Special fatty acid molecules were used as probes of the twin layers of fatty acids making up the cell membrane. By analyzing the response of the molecules to a fluctuating magnetic field, she found that membrane molecules became more mobile in response to alcohol.

The phenomenon, she said, may be "the first step in alcohol intoxication".

Mihai Demetrescu, a neurophysiologist at the University of California at Irvine, told the meeting that the experience of hallucinations appears to be related to a failure in a mechanism which inhibits the repeated firing of brain neurons.

In his experiments, electrodes were inserted into the brains of cats drugged with ketamine, an anaesthetic which causes hallucinations in humans recovering from surgery.

Neurons in the visual cortex could be made to fire repeatedly under the influence of ketamine, whereas in the undrugged state the cells would not fire again without a "rest" of about one tenth of a second, he said. A similar disinhibiting effect has previously been observed during dreaming.

"In the brain there are basically two processes, excitation and inhibition, and there is a continuous balance," he said in an interview.

"This is the first physiological evidence that both dreams and hallucinations occur when the barriers in our brain are down and information can jump over them."

New methadone warning

METHADONE retards tissue growth and inhibits cell division, according to a report presented to the meeting.

Ferdinand Hui, a pharmacologist at New York Medical College, said his findings cast doubt on the safety of methadone as a long-term narcotic substitute for heroin addicts, particularly for pregnant women.

Dr Hui studied tissue regeneration in the salamander, an animal which has the capability to regrow an amputated limb. Some of the amputated salamanders were injected with methadone; treatment reduced tissue regrowth by 26% over a four week period, he said.

He said he also injected radioactively labelled thymidine and uridine into the salamanders, excised tissue samples a day later and measured the uptake of radioactivity due to DNA and RNA synthesis.

DNA synthesis was reduced by 40%, and RNA synthesis by 96.2% compared to the controls, he said.

Dr Hui suggested in an interview that methadone should only be used for two or three months an "adequate" time to wean an addict from narcotics.

He said he suspects that heroin has the same growth-inhibiting characteristics as methadone.

Mom and dad were right, drugs up/grades down

A BOSTON study of 1,500 high school students has confirmed parents' intuition that when drug use goes up, grades go down.

Gene Smith and Charles Fogg of the Massachusetts General Hospital in Boston reported that drug abstainers had significantly higher grade point averages, lower absenteeism, fewer suspensions, and were more likely to graduate than users.

The five-year longitudinal study revealed that users of hard drugs (opiates, hallucinogens, amphetamines, barbiturates) had the worst records, while students who used marijuana only were intermediate between the abstainers and hard drug users on all four criteria.

COLLISION COURSE

AWARD WINNER!
"Best of Audiovisual Media Festival"
– BIOCOMMUNICATIONS'76

Content and Purpose

"Collision Course" is a dramatic essay which explores the potentially tragic consequences of mixing even moderate amounts of alcohol with the complex task of driving.

It is designed to impress upon the viewer that one is at risk even when generally socially-acceptable drinking behavior is practised.

The viewer is introduced to a young middle-class couple and their parents. The film follows the young couple's activities throughout the evening; taking in a movie and having a few beers with friends. At the same time, their parents are discussing some known facts relating to problems contributing to the carnage on the roads. Also introduced is a blue collar worker who, after a tiring day on the job and a couple of after-work drinks, takes to the highway.

The film dramatically analyzes the behavior of the indviduals involved and their subsequent actions.

As the audience is geared to suspect from the first, the young couple and the blue collar worker eventually meet . . . in the middle of the night on a lonely road.

Audience and Use

Collision Course is an action film which is ideal for use with a variety of audiences (e.g. driver education programs, driver training courses, home and school associations, student groups, community action groups). Community workers in the alcohol and drug dependency field will find this film a valuable teaching aid in the exploration of legal, social and behavioral aspects of drinking-driving issues.

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This film will not be available until May 7, 1976

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16mm, color film , 17 minutes

Societies 'deserve what they get'

(continued from page 16)

traordinary variety of anthropological and historical evidence that at other times, and in other cultures at the present time, "disinhibition" and "social disruption" are by no means the inevitable result of intoxication. MacAndrew maintains that each society teaches the kinds of drunken comportment it will allow and that in Western societies, because intoxication is considered a "time out" period when a person is understood not to be responsible for his behavior, almost anything goes. He notes that this does not have to be so; even in our own culture there are individuals who do not behave deviantly no matter how intoxicated they become ("he can really hold his liquor") and many intoxicates often "sober up" remarkably fast in the face of stressful situations. He concludes with a warning that may be prophetic: "Since societies, like individuals, get the sorts of drunken comportment that they allow, they deserve what they get."

Given the arguments of critics such as Fingarette and MacAndrew and the potential consequences of a change in the law, the absence of any controversy over the revision of Section 523 is surprising.

Hutt's assurance that there would be "no dislocations" seems questionable. Already the American Civil Liberties Union has testified for the change. And from Kansas City has come the report that legal aide attorneys secured a pardon for a man who had spent nearly half of his 42 years in prison for "crimes resulting from alcoholism".

It is generally accepted that a considerable proportion of criminal activity is alcohol-related and it seems a reasonable expectation that intoxicates charged with crimes — or their attorneys — would avail themselves of a defence of alcoholism. As Fingarette points out, the difficulty is that the definition and diagnosis of the "disease" is anything but precise. If the law is changed, would we then see the development of a new class of expert witnesses, forensic alcohologists, who would battle through the courtrooms of the land in an attempt to convince bewildered juries that defendants are or are not "alcoholic"? And what of the crimes that could be excused because they were the result of involuntary intoxication?

In light of judicial extensions of the **Powell** decision, the hypothetical case offered to the Advisory Council by Hutt, of an alcoholic who burgles a liquor store for alcohol to relieve his craving, seems disingenuous. What about the "alcoholic" who, when intoxicated, in the words of the ACLU "can't appreciate the wrongfulness of his conduct" and annihilates a family on the highway? Or who rapes or murders because he "lacks substantial capacity to conform to the law"?

If MacAndrew is correct in his assertion that even the present law, which permits intoxication as a defence when intent or knowledge must be proved, is based on false data, then would a change in the Federal Code extending the same defence to recklessness and negligence represent a humane liberalization, as its supporters contend? Or, would it represent the codification of a dangerous cultural myth?

For the present, such questions go unanswered as liberals and conservatives continue to debate other controversial sections of S.1. Liberals are especially exercised over other provisions in the law concerning government secrets and the death penalty and, according to Jay Lewis, editor of *The Alcoholism Report*, the bill "appears to be all balled up and going nowhere this session barring an unexpected breakthrough".

At this point, no one is debating Section 423, and what it will look like when the Senate finally reaches a compromise on the law is a matter of conjecture. Morris Chafetz, director of NIAAA when the Advisory Council sent its resolution to Weinberger, writes that the proposed revision is still under "active consideration" and believes the prospects for its passage "excellent". Like Peter Hutt, he considers the revision "crucial". It will provide the impetus to further remove such people from the judicial system into a humane, hopefully, health system". But John McClellan, the conservative Senator from Arkansas whose committee still has jurisdiction, seems neither so sanguine nor approving of the proposed change. He writes: "S.1 has never had a provision that would permit alcoholism to be used as a legal defence in criminal cases. Intoxication may be a defence under current case law under certain circumstances and S.1 carries this case law forward in Section 523."

For now, that's the bottom line. What will happen in the future remains to the seen. All anyone can predict is the truism that whatever its final form, Section 523 will have a profound effect for years to come on alcoholic criminals — and their victims.

More Letters...

(continued from page 4)

accused during disposition and issuance of restraining conditions, the accused will no longer have the problem which led him/her to crime. Regretfully, most judicial dispositions are still carried out with this supernatural philosophy.

Thanks for **The Journal.**

Robert (Bob) W. Turner
Chief Probation Officer
San Angelo, Texas 76901

'Radical chic'

Sir:

As a concerned professional in the drug abuse field I must take exception to Ms MacLennan's report through rose-colored glasses on the disruption of the NDAC by the United Harlem Drug Fighters (Harlem Drug Davids take on New York Goliath, **The Journal**, May).

Ms MacLennan's coverage is straight out of the '60s "radical chic" adulation of violence in the service of social reform. Seems that to Ms MacLennan extremism in the defence of social reform is no vice.

The fact that the disruptors pushed, shoved, and verbally abused the conferees was glossed over by her. Perhaps this whole scene was titillating to her (what's a nice middle-class girl from Toronto doing in dirty - crime - ridden - New York anyway?) but to those of us who contend with the problems of this city on a daily basis it was just a dreary repetition of a by now familiar scenario of demonstrations, threats of violence, and token governmental capitulation.

If Martha Davis and her foul-mouthed entourage of self-styled storm troopers stand for anything it's the gangster/fanatic mentality that condones violence and threats of violence as legitimate grantsmanship tactics. What is amusing and harmless to Ms MacLennan in New York would be something else again if the mob went for the Addiction Research Foundation's funding.

Then it would be scary, not funny. But then, the rule of the club always is to the Clubee.

Phillip E. Jacobs, PhD
Director, Drug Abuse Treatment Programs
Long Island Jewish-Hillside Medical Center
New York 11040

The Journal welcomes Letters to the Editor. Letters may be sent in care of The Journal to 33 Russell, Toronto, Ontario, M5S 2S1.

Laborers burn thousands of tons and millions of dollars worth of green dagga in the marijuana fields of South Africa. Despite intensified police efforts in the Golden Triangle, traffickers are taking bigger risks than ever before and fresh sources of supply are constantly being opened up — particularly in the Far East, Africa and Latin America.

Police efforts to intensify in Golden Triangle

By Thomas Land

GENEVA—North American law enforcement authorities concerned with the illicit traffic of drugs from the notorious Golden Triangle via Hong-Kong across the Pacific are likely to intensify their vigilance.

Several criminal organizations specializing in the drug traffic in the British colony were recently rendered inoperative there, but they have re-established their supply links.

Delegates from some 30 countries attending a meeting here of the United Nations Commission on Narcotics have been told recent large seizures of illicit drug consignments have driven prices on the black markets of the industrialized world to such high levels that the supplier gangs are now taking far greater chances than ever before in their war against each other and the authorities for a financial share.

In Malaysia, for example, traffickers are now liable to life imprisonment—but the penalty has failed to produce a deterrent effect. Fresh sources of supply are thus constantly being opened up, especially in the Far East, Africa, and Latin America.

Several clandestine laboratories manufacturing heroin in Hong Kong were recently destroyed and large quantities of opium seized by the local authorities, says the UN's International Narcotics Control Board.

In addition, Thai authorities prevented for some time the smuggling of opium and morphine base to the colony by fishing trawlers. As a result, the traffic was disrupted and there were shortages on the local illicit market. This led many Hong Kong addicts to apply for proper treatment.

But, there is evidence the territory is being supplied again as there is no longer any shortage of heroin on the market. "Drug abuse control will therefore call for extreme vigilance on the part of the authorities," a UN specialist advises.

Efforts are being made by Thailand, Laos, and Burma, parts of which comprise the Golden Triangle, to eliminate opium production—but with little hope of success in the foreseeable future. There is, in fact, evidence increasing quantities of heroin are being manufactured near the opium producing areas.

Nevertheless, a promising crop substitution project undertaken in Thailand by the administration and the Division of Narcotics Drugs have demonstrated that poppy growers are willing to turn to alternative crops as long as they are assured an adequate market and fair prices. Yet opium abuse persists and heroin addiction is spreading in the country. The Thai produce is exported in increasing quantities to the Malaysian peninsula as well as Hong Kong and thence to the international markets.

But the role of Laos as a supply route for illicit opium appears to have been diminished. Most opium produced by the hill tribes is consumed locally. An internationally aided preparatory study is currently under way and aimed at a comprehensive, national program of crop substitution and treatment and rehabilitation for addicts.

Drug addiction in Burma has assumed disturbing proportions even by local standards. Opium and opiates are the principal substances used, but addiction to heroin (which is smoked as well as injected) has recently spread among young people in the urban centers.

Under a new national law, doctors and village headmen are obliged to register drug addicts for treatment; but the capacity of treatment centres at Rangoon, Myitkyma and Putao is insufficient.

The illicit and uncontrolled production of opium, particularly in the Shan State, continues at a high level, despite intensifying governmental action against the traffickers who provide an outlet for the crop. Large seizures have been made recently, and several clandestine laboratories dismantled. As a result, less opium and opiates seem to be reaching the frontier with Thailand despite uninterrupted production. The traffickers are being hunted down in the cities to face recently intensified penalties.

Burma, too, is preparing to launch a crop substitution program in order to provide opium poppy growers with an alternative source of income. The operation will be long and arduous, forecasts an official of the Narcotics Control Board, but it demonstrates the authorities' desire to tackle the problem at its roots.

Stigma remains for female alcoholics

By Harvey McConnell

LONDON—Most people hold the female alcoholic in lower esteem than her male counterpart and this may in turn influence the way they are helped professionally, suggests a study by researchers at the Institute of Psychiatry here.

Dr Gloria Litman and colleagues analyzed the opinions of more than 200 people, half drawn from non-psychological staff and students at the Institute, and half from two small businesses — a publishing house and a chartered surveying company.

None of those questioned about various female attributes were aware of the object of the inquiry.

Dr Litman said the results "clearly confirm the possibility that people in general hold the female alcoholic in low esteem". In some cases they are regarded as devoid of personality.

The findings suggest women's recovery and return to normal social functioning must be markedly impaired and retarded.

Dr Litman emphasized: "A positive finding in this case cannot prove that professionals in alcoholism have implicitily adopted the cultural evaluation of the alcoholic female, but that has become a tenable, and testable, proposition."

"It may, in some ways, mimic the double-standard—that it is more acceptable for men to be unstable than it is for women, in this case implying that the stability of home and culture is dependent upon women but not men."

As the study showed that female alcoholics were perceived in a relatively unsympathetic manner by laymen, it may also imply that the illness concept of alcoholism has not overtaken other explanations, such as "lack of will power" or "weak character", she said.

"This outcome suggests that official public policy in educating people with respect to alcoholism has not been particularly effective," Dr Litman added.

Lastly, their data suggests strongly that the self-esteem of female alcoholics may be very low or impaired in other ways. This is a factor that needs to be considered more strongly in therapeutic programs and individual treatment.

Dr Litman continued: "It would also be interesting to know if low self-esteem or self-regard were of etiological significance—suggesting that women begin to drink excessively when their self-esteem approaches that level which is regarded as consistent with, or characteristic of, alcoholic women in general."

West Germans break their own record, alcohol consumption triples since 1950

By John Dornberg

MUNICH—West Germans are consuming more alcohol today than at any time in their history.

Moreover, only 10% of West Germany's male, and 30% of its female population can be regarded as total abstainers.

These are the conclusions of a study conducted by the Max Planck Institute of Psychiatry here on behalf of the German Anti-Addiction Centre in Hamm.

According to the survey, per capita consumption of alcohol has increased to 11.6 liters in 1974 from 3.6 liters in 1950. The most popular beverages, in that order, are beer, wine, and spirits.

Alcohol consumption and abuse also appear to be increasing more rapidly among females and juveniles of both sexes than among adult males.

Fifteen years ago, according to the institute, only 10% of the known alcoholics and problem drinkers in West Germany were women. Today they represent 20% of the total.

Eighteen percent of all West Germans, the survey revealed, feel they need to go on drinking once they have had some alcohol and a similar percentage have experieneed alcoholic blackouts on at least one occasion.

The report revealed that cigarette consumption increased even more sharply during the same 15-year time period.

Per capita consumption of cigarettes was 497 in 1950 and had risen to 2,065 in 1974.

Every fourth teenager between the ages of 14 and 16 is a "regular smoker".

Around the World

Betel nuts

The New Guinea government has launched a campaign to educate the public about the dangers of chewing betel nuts. There are increasing signs of a close relationship between chewing the euphoria-producing nut and the incidence of mouth cancer.

Italian connection

Italian youths are reportedly expanding their usage of drugs and there is also a growing tendency to begin drug trips with heroin rather than a 'softer' drug according to officials. Stiffening penalties for hard drug pushers and a new network of detoxification centres are part of the country's attempts to deal with its drug and alcohol users.

Smugglers

Pakistan is readying itself for large-scale infiltration by organized syndicates into its opium trade. Arrests of foreign smugglers have climbed dramatically in the past several months and the government has discovered illicit laboratories producing opium products.

Youth crimes

Czechoslovakia officials say nearly 40% of all juvenile crimes are committed under the influence of alcohol. Increased juvenile drinking in Czechoslovakia has been attributed to price. Soft drinks are more expensive than beer.

Young drinkers

About 10% of West Germany's alcoholics are under the age of 25. The government has allocated approximately $9 million to combat the disease among its one million alcoholics.

Locked doors

The Roumanian government has closed 2,000 bars and taverns throughout the country in a mass campaign against alcohol abuse. The establishments have been converted into restaurants, bakeries, and pancake houses.

New Books

by RON HALL

Information and Feedback for Evaluation

. . . edited by Barry Willer, Garry H. Miller and Lucie Cantrell

Selected papers from the Annual Information and Feedback Conference are presented. The topic of this 1974 conference was "Systems Approach to Program Evaluation" and the papers are divided into sections including: program evaluation, clinical evaluation, and information systems. Issues concerned with alcohol are raised in two presentations.

(York University, Communications Department, Toronto, Ont., 1975. 117p.)

Other Books

Communication Research and Drug Education—Ostman, R. E. (ed). Sage Publications, Beverly Hills, 1976: Mass media, educational systems, impact on audiences, evaluating drug-related messages, problems and solutions. 325p.

Balancing Head and Heart: Sensible Ideas for the Prevention of Drug and Alcohol Abuse. Book 1: Prevention in Perspective—Schaps, Eric, Cohen, Allen Y., and Resnick, Henry S. Prevention Materials Institute Press, Lafayette, 1975: Extent of the problem, developmental model, changing the schools. 114p.

Balancing Head and Heart: Sensible Ideas for the Prevention of Drug and Alcohol Abuse. Book 2: Eleven Strategies—Schaps, Eric, and Slimmon, Lee R. Prevention Materials Institute Press, Lafayette, 1975: Role playing, values clarification, creative drug education, alternatives, peer counselling, family life. 177p.

Drug Misuse and the Law: The Regulations — Hotchen, J. S. MacMillan Press, Ltd., London, 1975: Supplementary notes describing the Statutory Instruments made under the Misuse of Drugs Act 1971. 118p.

Coming Events

June

The Annual Conference of the National Coordinating Council on Drug Education—June 2-5, 1976, Minneapolis, Minn. Information: National Coordinating Council on Drug Education, 1526 18th St., NW, Washington, DC, 20036.

Annual Meeting of the Halfway Houses of North America—June 6-10, 1976, Edmonton, Alta. Information: International Council on Alcohol and Addictions (ICAA), Case Postale 140, 1001 Lausanne, Switzerland.

22nd International Institute on the Prevention and Treatment of Alcoholism—June 7-12, 1976, Vigo, Spain. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

3rd Biennial Symposium on Biomedical Alcohol Research—June 7-11, 1976, Lausanne Switzerland. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

The Committee on Problems of Drug Dependence—June 7-9, 1976, Richmond, Virginia. Information: NAS-NRC, 2101 Constitution Ave., NW, Washington, DC, 20418.

Primary Prevention Conference—June 9-11, 1976, Boiling Springs, Pa. Information: Phyllis Hirschfield, Coordinator, South Central Regional Addictions Prevention Laboratory, 3964 Jonestown Rd., Harrisburg, Pa.

9th Annual Eagleville Conference on Alcoholism and Drug Addiction—June 10-11, 1976, Eagleville, Pa. Information: Patricia Moretti, Conference Registrar, Eagleville, Pa, 19408.

The Public Inebriate—June 17-18, 1976, Washington, DC. Information: The Washington Area Council on Alcoholism and Drug Abuse, 1330 New Hampshire Ave., NW, Washington, DC, 20036.

11th Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies, INFORMACTION—June 20-25, 1976, Toronto, Ont. Information: William Gilliland, Conference Manager, Addiction Research Foundation, 33 Russell St., Toronto, Ont., M5S 2S1.

Rap Round-up 1976—June 25-27, 1976, Swan Lake, New York. Information: RAP, Box 95, Staten Island, New York, 10305.

6th International Institute on the Prevention and Treatment of Drug Dependence—June 28, July 2, 1976, Hamburg, Germany. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

July

Potsdam Institute on Alcohol Problems—July 12-23, 1976, Potsdam, New York. Information: Dr Louis LaGrand, Institute Director, State University College, Maxcy Hall, Potsdam, New York.

Alcoholism and Other Drug Dependencies 1976 — July 29-30, 1976, Seattle Wash. Information: The Alcoholism and Drug Abuse Institute, University of Washington, Seattle, 98195.

August

11th International Conference on Medical and Biological Engineering—Aug. 2-6, 1976, Ottawa, Ont. Information: Conference Office, National Research Council, Ottawa, Ont., K1A 0R6.

17th Institute on Addiction Studies—Aug. 15-20, 1976, McMaster University, Hamilton, Ont. Information: David E. Reeve, 15 Gervais Dr., Suite 603, Don Mills, Ont.

Symposium on Drug Dependence, Alcoholism and Criminality—Aug. 16-20, 1976, Sao Paul, Brazil. Information: ICAA, Case Postale, 140, 1001 Lausanne, Switzerland.

9th International Conference on Health Education — Aug. 29-Sept. 2, 1976, Ottawa, Ont. Information: Canada's Organizing Committee, 9th International Conference on Health Education, C/O Canadian Health Education Specialists Society, PO Box 2305, Station D, Ottawa, Ont, K1P 5K0.

September

Second International Symposium on Victimology—Sept. 5-11, 1976, Boston, Mass. Information: 156 Federal St., Boston, Mass.

In order to provide our readers with adequate notice of forthcoming meetings, please send announcements as early as possible to: The Journal, 33 Russell St., Toronto, Ont., M5S 2S1.

Positions Available

CHEMICAL DEPENDENCIES SPECIALIST

to manage a multi-disciplinary outpatient treatment program. Advanced degree in a mental health field and treatment services experience essential. To begin July 1.

Contact: **Dane County Mental Health Center,**
31 South Henry Street,
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Personnel Department
Addiction Research Foundation
33 Russell Street
Toronto, Ontario M5S 2S1

Alcoholic criminals

Are they sick or are they guilty?

By Phil Penningroth*

Section 523 of the US Federal Criminal Code reads:

Intoxication

(a) Defense.—It is a defense to a prosecution under any federal statute that the defendant, as a result of intoxication, lacked the state of mind required to be proved as an element of the offense charged if:

(1) intent or knowledge is the state of mind required; or

(2) reckless or negligence is the state of mind required and his intoxication was not self-induced.

Intoxication does not otherwise constitute a defense.

(b) Definitions.—As used in this section:

(1) "intoxication" means a disturbance of a mental or physical capacity resulting from the introduction of alcohol or a drug or other substance into the body;

(2) "self-induced" intoxication means intoxication caused by a substance that the actor knowingly introduces into his body with knowledge that it has, or with reckless disregard of the risk that it may have, a tendency to cause intoxication.

In September, 1974, the Advisory Council to the National Institute on Alcohol Abuse and Alcoholism unanimously passed a resolution recommending that alcoholism be a defence to prosecution "to the same extent and under the same conditions as any other illness".

Other 'diseases'

This resolution was forwarded to then Secretary of Health, Education and Welfare, Caspar Weinberger, with the request that he forward it with his endorsement to the Senate Subcommittee on Criminal Laws and Procedures which has for some time been preparing a revision of the Fedcral Criminal Code (S.1). In July, 1975, Weinberger complied, and in a letter to Senator John McClellan, Chairman of the Subcommittee, detailed the rationale for his support of the Advisory Council's Resolution:

"... where a reckless or negligent state of mind must be proved with respect to an element of an offence, the proposed code would deny a defendant who lacked that state of mind because he was intoxicated as the consequence of suffering from alcoholism, a defence that would be available to a defendant who lacked that state of mind because of some other illness. We understand the Advisory Council's Resolution to be opposed to this distinction between alcoholism and other diseases..."

To most alcohologists, the Advisory Council's Resolution and Weinberger's recommendation seem simple justice grounded in common sense. Alcoholism *is* a disease, the chief symptom of which is loss of control. Isn't it just as unjust to hold an alcoholic responsible for behavior that *is* the result of drinking he could not control as it is to hold a mental patient responsible for behavior that is the result of his "mental defect"? Moreover, the knowledgeable argue, such a change in the code would really do no more than bring the statutes into line with federal legislation and current case law. Such was clearly Peter Hutt's point of view when he testified in favor of the revision of Section 523 before McClellan's committee in May, 1974.

Peter Hutt is one of the most experienced attorneys in the United States concerning alcoholism and criminal responsibility. At the time he testified (as a private citizen) and, later, when he authored the Advisory Council Resolution, Hutt was Chief Counsel for the FDA. Before that, however, in private practice he had been involved in the three landmark cases on the issue. In his testimony Hutt briefly reviewed the relevant law.

Ambiguities

In the case of **Easter** v. **the District of Columbia**, a United States Court of Appeals (which included now Chief Justice Burger) held that an alcoholic cannot be guilty of the crime of drunkenness under standard common law principles because he lacks the requisite mental intent; his drinking is an involuntary symptom of a disease.

In **Driver** v. **Hinnant**, another Court of Appeals extended the **Easter** decision: It found that punishing an alcoholic for drunkenness is a violation of the Eighth Amendment prohibition against cruel and unusual punishment.

Hutt himself argued **Powell** v. **Texas** before the Supreme Court and although his client lost the appeal 5-4 on a technicality, the dissenting minority plus Justice White agreed that an alcoholic cannot be jailed for manifesting an "involuntary" symptom of his disease—in Powell's case not just drunkenness, but appearing drunk in public.

Hutt's Senate testimony is worth reviewing in some detail because it represents the clearest statement of the currently prevailing point of view on the subject. As did Weinberger some ten months later, he was careful to distinguish between alcoholism and simple intoxication as a defence: "What would be required (he stated) would be to establish the causality between that illness... and the crime committed, and to show that except for that illness (the alcoholic) would have been able to prevent his action".

Just what kind of "action" might an alcoholic be unable to "prevent"? Hutt mentioned with approval the courts' extension of the **Easter** decision from "simple drunkenness to disorderly conduct and other charges" and, in the context of demonstrating that public protection would in no way be diminished by such judicial largesse, also noted that the State of New Hampshire has allowed alcoholism as a defence even to murder for 105 years without "any dislocations".

It is in Hutt's response to Committee questions, however, that the issue comes into sharpest focus:

Senator Hruska: *Is it your view, Mr Hutt, that intoxication itself should constitute a disease or be considered a disease in the meaning of an insanity defence?*

Mr Hutt: *Clearly it would be my point of view that it should not... If I were to go out and get drunk and commit some crime, I should properly be held accountable for my action because, as a nonalcoholic, I have every capacity to refrain from drinking... The alcoholic... is under a form of compulsion... to consume alcohol, and thus under the cases I have mentioned he has been held not accountable for the subsequent inebriation.*

Senator Hruska: *How readily is it determined that one is an alcoholic rather than a nonalcoholic?*

Mr Hutt: *... It is no more easily determined whether one is an alcoholic or nonalcoholic than whether one is mentally ill... As in many cases of criminal law, it is an issue that is ultimately left up to the jury... All that I am suggesting is that, rather than denying the possibility of the issue being decided by the jury, it should be put to the jury.*

Although it is clear from the Advisory Council's support of Hutt's position that his is the establishment point of view in alcohology, there are those who question the assumptions upon which any defence of intoxication or alcoholism is based—the "fact" that intoxication is an "involuntary" consequence of alcoholism and the belief that intoxication "causes" socially deviant behavior.

In *The Perils of Powell: In Search of a Factual Foundation for the Disease Concept of Alcoholism* (Harvard Law Review, 1970), Herbert Fingarette examines the arguments of the dissent in the **Powell** decision and comes to the conclusion that in an attempt to improve the lot of chronic alcholics, alcohologists and the courts have followed an understandably tempting but dangerous road to reform—"... the building of new constitutional doctrine on the basis of purported medical knowledge of alcoholism".

Compulsiveness

The **Powell** dissent, Fingarette argues, is based on a questionable "finding in fact", namely:

"1) That chronic alcoholism is a disease which destroys the afflicted persons' willpower to resist the constant excessive consumption of alcohol, and;

2) That the alcholic does not appear in public by his own volition, but under a compulsion symptomatic of the disease of chronic alcoholism."

In a thorough review of the relevant literature Fingarette finds not just disagreement about the definition of alcoholism, but also only ambiguous and conflicting support for the "disease concept" and the corollary assumption that alcoholics cannot control their drinking. Available evidence, he asserts, in no way proves the "medical fact" that an alcoholic is "compelled" to drink; there is, he notes, considerable disagreement among alcohologists about the existence, not to mention the cause of this "compulsion". Even those who posit a physical hypothesis for "loss of control" do not claim there is no volition in the alcoholic's excessive drinking, but only that "partly because of a physical abnormality, the alcoholic is one who faces a choice which is (increasingly) more difficult than for most people". Fingarette concludes:

"... The widespread (but by no means universal) acceptance in the medical and health professions of the 'disease concept of alcoholism' reflects a variety of considerations which are legitimate and important to the health professions, but... none of these considerations have any obvious bearing on the legal issue of punishability under the Eighth Amendment."

THE BACK PAGE

In the book *Drunken Comportment* (Aldine, 1969), Craig MacAndrew takes exception to the concept implicit in the second premise of Fingarette's syllogism and explicit in court extensions of the **Powell** decision — that alcohol causes people to lose control of their behavior.

As MacAndrew notes, the belief that under the influence of alcohol people become "uninhibited" is as time honored as it is pervasive. Western literature—popular, political and scientific—is replete with examples of the power of alcohol to interfere with judgement and "inflame the passions".

It is MacAndrew's argument that while it may be possible to establish a causal connection between intoxication and physical effects such as slowed reflexes, it is clearly impossible to establish the same connection between intoxication and behavior. He recognizes that when people become intoxicated they behave in ways they do not when sober, but to assert that alcohol *causes* the behavior is analogous to suggesting that eating sugar causes a diabetic to break his diet — or into a candy store. Unquestionably, he agrees, too much alcohol can cause physical changes, some of which may be quite severe, but the substance itself cannot *make* us do anything.

To support his thesis that social expectations rather than alcohol are the "cause" of deviant drunken comportment, MacAndrew presents an ex-

(See — Societies — Page 12)

* *Mr Penningroth is Alcohol Program Coordinator with the Department of Mental Health Services, Kern County, California.*

'Who is guilty: The Alcoholic or the Alcohol?'

Pot still clouds drug scene

By Bryne Carruthers

OTTAWA — Despite a slight drop in drug convictions across Canada, 1975 drug statistics from the Bureau of Dangerous Drugs reveal that marijuana remains the major drug problem in the country, at least on the basis of police and court activity.

During 1975 there were 28,733 total drug convictions under the Narcotic Control Act, of which 27,367 (or 95%) involved marijuana and hashish.

The dominance of marijuana crimes was further reflected by a noticeable increase in the percentages of absolute and conditional discharges given as sentences for the "convictions". (Technically, persons given the discharges are not convicted, though they are found guilty. But the federal drug statistics lump them in with true convictions, for comparison purposes).

At the same time, the police policy of trying to go after pushers and importers seemed to pay off in 1975, with significant increases in convictions for trafficking, possession for the purpose of trafficking, and, largest of all, importing.

Heroin convictions, though, were down sharply from 1974, while cocaine convictions and phencyclidine (PCP) convictions were up, reflecting a shift in popularity to cocaine and the skull-popping veterinary tranquilizer, respectively.

More specifically, there were 511 heroin convictions, a decrease of 35.9% from 1974; 467 phencyclidine convictions, up more than 80%; and 289 cocaine convictions, up 22%.

Total convictions and marijuana convictions dropped by almost 5.8% compared to 1974.

But while possession convictions dropped 7.7% to 25,880 cases, trafficking convictions

(See — Marijuana — page 3)

The Journal

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Smokers help pay for Olympic deficit

A new saying in Quebec is that every time someone lights a cigarette, part of the Olympic games deficit goes up in smoke. A 10-cent-per pack tax on cigarettes, over and above present levies, has recently been introduced and is expected to draw $90 million toward paying off the Olympic deficit. Premier Robert Bourassa, a non-smoker himself, said complainers can just stop smoking and help reduce health costs at the same time.

INFORMACTION

'Dialogue on drinking' planned by Ottawa

By Gary Seidler

TORONTO — A national information program labelled "Dialogue on Drinking" — will be launched by the Federal government this fall, Health Minister Marc Lalonde has announced.

Mr Lalonde was expected to provide a preview of the planned media program at the final session of INFORMACTION, the 11th annual conference of the Canadian Foundation on Alcohol and Drug Dependencies.

In a prepared text, Mr Lalonde said the information campaign would deal with five major problem areas and would be directed at "moderate" drinkers.

The problem areas to which campaign messages are being designed are: drinking-driving; teenage drinking; alcohol related violence; the serious health effects of heavy drinking; and the effects of drinking on job performance.

Mr Lalonde indicated that the impetus for the program came from an April, 1975, meeting of Canada's health ministers who agreed that alcohol abuse constitutes a major area of national concern.

The health minister emphasized that "Dialogue on Drinking" was not designed to solve all alcohol-related problems. Like any other information/publicity program, it would be only a part of a total program which must integrate education, community action and social policy change.

Mr Lalonde said his department recognized that media is not an effective way to reach people who drink dangerously. Consequently, the federal messages will not attempt to reach hazardous drinkers but the majority of Canadians who drink responsibly.

He said this did not constitute preaching to the converted, and there are good reasons for addressing moderate drinkers: —

- "We" want them (moderate drinkers) to maintain their responsible approach to drinking. "We" want to reinforce the attitudes which causes them to keep their consumption within strict, self-imposed limits;
- "We" want them to share their convictions with immedi-

(See — Ottawa — page 6)

Human experimentation threatened

'Subjects' rights' stunt research

By Milan Korcok

MIAMI BEACH — Civil liberties attorneys and politically-motivated power groups are assuming increasing authority over setting the groundrules for human experimentation, Roger E. Meyer, Harvard psychiatrist told the American Psychiatric Association.

This shift has seriously impeded many potentially-valuable research initiatives in the field of addictions and has, under the guise of "subjects' rights", thrown many scientists in bio-medical and behavioral studies back on the defensive, he added.

Roger Meyer

Dr Meyer is director of the Harvard-Boston University Center for Biobehavioral Studies in the Addictions. He cited case examples whereby community and or federally-constituted "patient advocate" groups have successfully halted legitimate research projects involving human experimentation.

The result has been to construct a scientist/social advocate confrontation which the scientist with his resources is ill-prepared to meet, said Dr Meyer.

"Alcoholism and drug addiction are major behavioral disorders whose alteration will require one or another form of behavioral modification. Indeed, methadone maintenance, narcotic antagonist treatment, and self-help residential programs all seek to modify behavior."

Yet the foundation of behavioral experimentation is coming under extreme stress, said Dr Meyer, who cited Congress' intervention in Harris B. Rubin's research project on the effects of marijuana upon human sexuality at Southern Illinois University as but one example of the trend. Dr Rubin had already been granted support and approval for this project by NIDA when a group of congressmen, headed by Senator William Proxmire, managed to intervene, characterizing it as a somewhat capricious sexual venture.

In his report to the APA, Dr Meyer did not challenge the need for supporting patients' rights, for adhering to strict codes regulating human experimentation, or for retaining vigilance in respect to patients' privacy and confidentiality. His concerns are focused on what he characterized as an exploitation of these rights for political motivations.

"This is a dangerous trend which may have moved beyond its initial noble impulse.

"In some circles, science and technology are viewed as arrogant, elitist, and too powerful against the needs and desires of individuals. In this context, our political system has seemed to be moving to set up countervailing forces and adversary procedures designed to equalize the interaction.

"When viewed from this perspective, the practice of science and technology is (seen as) equivalent to the practices of the giants of industry in earlier times.

"Objectivism, intellectualism, and the pursuit of knowl-

(See — Research — page 9)

Inside

Biomedical research effort weighed in US

See page 6

Alcohol abuse a 'national crisis'

By John Carroll

FREDERICTON — A doctor and surgeon who is a veteran member of the New Brunswick Legislature recently termed alcoholism the major social problem in Canada today and took critical aim at provincial governments, including the one of which he is a member, for lowering the drinking age and fostering teenage alcoholism.

Everett Chalmers (PC — Fredericton South) told the Legislature adults have no right to condemn young people for drinking when they set the example in a problem that has become "a national crisis".

The former chairman of the Select Committee of the Legislature which reported in April, 1972, to the House on alcoholism, maintained most of the recommendations in that report are still valid and it is time for "some positive action" on them.

The speech was a highlight of debate on the estimates of the department of health: The subject being debated during committee of supply was $1.8 million allocated for the province's alcoholism program.

In New Brunswick, Dr Chalmers said, 5,000 citizens are in need of clinical treatment for alcoholism, while another 12,000 are using alcohol "in dangerous quantities".

The cost of alcoholism in New Brunswick is an estimated $29 million in the current year, and the disease ranks third as a killer after heart disease and cancer.

Referring to the concern expressed by some parents over an unproven link between budworm spraying and Reye's Syndrome, a usually fatal children's disease, Dr Chalmers asked "why do they not react to the terrible destruction that is taking place in the physical and mental health of their children and family because of the abuse of alcohol by our students?"

He said children were learning to drink before they had learned to live and the lowering of the drinking age "has been a terrible mistake". This feeling was now prevalent in all provincial jurisdictions and additional proof was available from the "startling" statistics gathered by the Addiction Research Foundation of Ontario, he said.

Governments were at fault not only for lowering the drinking age from 21 years to 19 or 18 but for pushing alcohol.

"Governments provide most of the liquor and alcoholic beverages that are consumed. There seems to be a greater urgency to have an outlet of some type on almost every street corner, motel, hotel, restaurant, club, mall, shopping centre, train, plane and boat," he said.

In the old days, Dr Chalmers said, the under-age drinker was 18-, 19- or 20-years-old. "In the bad new days, the under-age drinkers are from 13 to 17. I know one who started drinking at nine and was a total alcoholic at 13."

He asked the House if the province was going to recognize the problem for what it is or merely make a token effort. He said there was a need for a permanent rather than an interim commission on alcoholism, but as long as liquor is handled by an agency of government "it will always remain at the end of the list".

To combat the problem, he suggested the provincial alcoholism program "is entitled to 5% to 10% of the gross revenues of liquor sales for a starter." He said running around the province passing out pamphlets on alcoholism "is not worth a damn" and it is up to parents and teachers to get involved.

He said parents worry about drugs and thank God when a child comes home drunk but is not on drugs.

"The real reform will have to be achieved by parents and their example and counsel to their children. Are today's parents capable of disciplining themselves to save their children from alcoholism?" he asked.

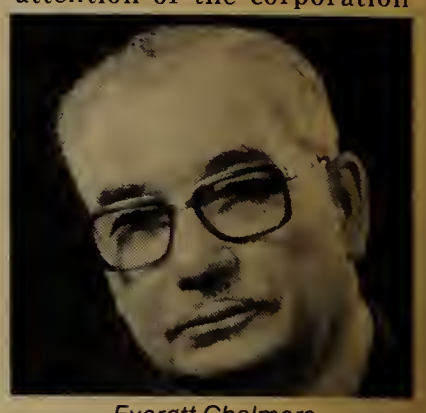
Dealing with the medical impact of this "self-inflicted" disease, Dr Chalmers said alcoholism could lead to death from a diseased liver, diabetes, heart attack, pancreatitis or arteriosclerotic gangrene. The unborn child of a drinking mother could be damaged by alcohol, while even sex activity was impaired, studies showing alcohol to be a secondary cause of impotence.

He said alcoholism was costing Canadians $1 billion annually and has reached the point of being a national crisis.

The hard-hitting speech drew thumping applause from both the Conservative government side and the Opposition benches.

Health Minister G.W.N. Cockburn said a permanent commission on alcoholism would be established in a couple of months and $43,000 was budgeted for it this year.

Finance Minister Ediaon Stairs told the House he shared the concerns expressed and as minister responsible for the provincial Liquor Corporation would "forcefully" bring to the attention of the corporation



Everett Chalmers

and the licensing board the views expressed in the debate, providing transcripts of the various remarks made by members.

FDA acts on propoxyphene deaths

WASHINGTON — The US Food and Drug Administration will recommend to the Drug Enforcement Agency that the pain-relieving drug propoxyphene be controlled under Schedule IV of the Controlled Substances Act.

When the DEA takes action on the recommendation, it will mean that propoxyphene (Darvon) can only be renewed five times on a single prescription, or that a prescription cannot be renewed after six months, whichever comes first. In addition, the pharmacist dispensing the drug will have to keep a record of all sales.

The FDA's proposed action follows widespread reports that overdoses of propoxyphene had been implicated in an increasing number of deaths in recent years. A large number of these deaths have been reported as suicides.

The DEA estimated there were 409 deaths from propoxyphene products during the first half of 1974 compared with 389 deaths the first six months of 1973. Data for the first six months of 1975 shows over 500 deaths from overdoses of propoxyphene.

The DEA urged that propoxyphene be listed under the Controlled Substances Act for some time. However, the FDA had not acted until now.

The DEA maintains that propoxyphene caused dependence along the lines of the narcotic drugs. Although the FDA is proposing to list the drug as a controlled substance, it is understood the agency does not regard it as a narcotic. Pharmacologists at the FDA regard it as an opiate, an FDA spokesman points out.

Much of the impetus for the latest move has come from a report by Arthur J. McBay, PhD, and Page Hudson, MD, of the Medical Examiner's office in Chapel Hill, North Carolina, published in the *Journal of the American Medical Association* last September.

The investigators reported what they called "an alarming increase" in deaths attributed to propoxyphene in North Carolina and suggested this was not limited to the state.

They said the medical examiner's office in North Carolina had reported 13 deaths in the first half of 1974; 17 in the last half of 1974; and 16 deaths in the first three months of 1975. This compared with an average of 39 deaths annually from barbiturates in the state in the years 1971 to 1974. They added that most of the deaths from propoxyphene were suicidal overdoses although some were accidental.

Eye diseases

Cannabis may provide relief

RESTONK, VA. — A low eyeball pressure without a high in the head is the aim of researchers working with synthetic derivatives of THC, the main psychoactive ingredient in marijuana.

It has been known for five years that marijuana smokers experience a reduction in intraocular pressure of about 25% and this knowledge is being used to find a treatment for glaucoma, an eye disease that is a major cause of blindness when elevated pressure destroys the optic nerve.

Keith Green, associate professor of ophthalmology and lecturer in physiology at the Medical College of Georgia, Augusta, says compounds have been developed that work in rabbits and monkeys. He was outlining his group's research to a science writers' seminar held by Research to Prevent Blindness, Inc.

"Current medical treatment is restricted to about three or four commonly used drugs, all of which produce undesirable side effects, and frequently surgery is the final outcome," Dr Green said.

The rabbit work shows that eye drops are taken up and circulated in the blood, and the drugs work both in the brain and in the eye. No tolerance has been detected after four months.

Dr Green said the search continues for derivatives that have no psychoactive effects, to prevent abuse of the drops, even though some of those now available have no such action in the doses prescribed to reduce pressure.

'Bonwiffle gradient': teens work at looking older

By Wayne Howell

PROFESSOR E. R. Bottomsworthy, the noted sociologist, is not too impressed with the recommendation of the Ontario Youth Secretariat that the drinking age in the province be raised to 19 years.

"In the first place," he told me, "the recommendation completely ignores the Bonwiffle gradient."

"The Bonwiffle gradient . . . .?"

"Yes — it's just another name for the A-S-P. As you should recall, it was Bonwiffle, in his classic experiment in suburban Philadelphia, who first classified teenagers according to their A-S-P, their Age-Spread-Potential. He found that the vast majority of teenagers were what he termed 'alpha' teenagers, young adults who exhibited a type of sociocultural pleomorphism which gave them an A-S-P of 3.5 years.

"In other words, they could pass for 18 at 14.5 years of age if they really worked at it. Only a relatively small minority were what he termed 'beta' teenagers who had a seriously compromised A-S-P because of delayed puberty. And an even smaller minority were 'gamma' and 'delta' types which we won't discuss here since their A-S-P only seemed to be manifest in other endeavors — such as getting into dirty movies."

"But what is the significance of this,"? I interrupted.

"Is it not obvious? The high A-S-P of the alpha teenagers — who comprise the majority — means that if they can pass for 18 they will have little trouble passing for 19. Only a small proportion at the end of the bell curve, the impure alphas — what Bonwiffle called the 'crypto-alphas' — and the fuzz-cheeked, soprano-voiced betas would be affected by this proposed change."

"But would not that be better than nothing?"

"Well it would be if you didn't take the A-S-O into account. As you will undoubtedly recall from my paper 'Age-Set-Overlap and the Beta teenager', the percentage of 14-year-olds who know someone who is 18 who will buy them booze is very high — and the percentage who don't know someone who is 19 who will do them the same favor is very low.

"Furthermore, Helmholtz picked up where I left off and went on to show that the percentage of 13-year-olds who know someone who is 15 who knows someone who is 18 but who don't know someone who is 15 who knows someone who is 19 is very low."

"But still . . . it appears that there is a small advantage to be gained," I said.

"I only wish that things were that simple," sighed the professor, "for when you add the A-S-P to the A-S-O and combine it with the E.I. of the P.I. then you see the folly of the whole Youth Secretariat proposal."

"The E.I. of the P.I. . . . what has that island province got to do with it?"

"I really wish," said the professor, fixing me with a stern glare, "that **The Journal** would pay me the elementary courtesy of sending someone who has done his homework. The E.I. of the P.I. is just shorthand for the Ethical Index of the Public Inebriate. My colleague Stringbahl has done the definitive study on this; he concluded that the percentage of old winos who will purchase on request — and for a modest 24 oz. retainer — a bottle of spirits for a young person who is one year below the drinking age but will not, out of a spirit of civic duty and public responsibility, seek to corrupt the manners and morals of a young person two years below the drinking age who makes the same request, is too small to be statistically significant."

"I see," I said, "and of course because of the age-spread-potential he probably couldn't tell the difference in age anyway."

"Right you are" said the professor.

Wayne Howell is an Ottawa physician and freelance writer.

Marijuana still dominates drug scene

(continued from page 1)
increased 28% to 889 cases; possession for purpose of trafficking jumped 15% to 1,811 cases; and importing convictions jumped 44.8% to 42 cases.

Cultivation convictions, usually restricted to marijuana, dropped 20% to 105 cases.

In terms of sentences, fines remained the leading choice of judges, but dropped slightly compared to 1974. There were 17,423 fines imposed as punishment (no mention of amounts), representing 60% of cases. In 1974, fines represented 63% of cases.

Discharges, both absolute and conditional, totalled 5,826 and represented more than 20% of cases, with more than half being conditional discharges (with a form of probation). In 1974, only about 18% of the cases involved discharges, with a slightly higher percentage being unconditional discharges.

Sentences of one month or less in jail were given in about 4.3% of cases, up from 3.3% in 1974. Sentences of one month to six months were also up slightly, being given in 3.3% of cases. But generally speaking, the more severe sentences were slightly less frequent, except those involving 12 years or more in jail.

By age groups, the bulk of convictions continue to involve persons in the 18 to 20 age group first (almost 40%); in the 21 to 24 group second (30%); in the 25 to 29 group (13%); and in the under 18 age group (10.6%). Compared to 1974, there seems to have been a slight shift into the 25 to 29 age group and a slight drop in the under 18 age group.

By sex, males continue to outnumber females by more than 10 to one.

By region of the country, Ontario leads the nation with 10,605 of the 28,733 convictions; British Columbia is next with 5,974 convictions; Alberta is third with 3,806; and Quebec is fourth with 2,828.

In terms of marijuana convictions alone, 25,056 were for possession out of 27,367. Only 34 were for importing, with 649 for trafficking and 1,523 for possession for purposes of trafficking. There were 105 convictions for cultivation.

There was one conviction for marijuana possession that resulted in a sentence of two to three years in jail and 14 for one to two years in jail. Most got fines or discharges.

Marijuana traffickers tended to get jail sentences of one year or less, with six involving jail of three to four years.

Thirty of the 34 marijuana importers got seven to eight years in jail while two were given probation or suspended sentences.

For heroin, BC continued as the leader, with 324 of the 511 convictions. Ontario and Alberta were next, with 65 and 67 respectively and Quebec was fourth with 42 convictions.

For possession of heroin, most sentences were under a year in jail, a fine, or probation or suspended sentence. Trafficking in heroin resulted in sentences averaging between three and six years, with 10 cases involving more than eight years in jail.

Ontario was the hotbed for phencyclidine convictions, claiming 307 of the 467. Quebec was next with 64, followed by Nova Scotia with 38 cases.

Cocaine was a problem in BC (with 119 convictions), Ontario (90), Quebec (with 33 cases) and Manitoba (with 26).

Among the medical drugs, methamphetamines caused the most problems, with 131 convictions out of 183, followed by barbiturates (27), amphetamine (12), and methaqualone (11).

Among the psychedelics; LSD still leads the pack with 1,570 convictions out of 1,903, with most of them in Ontario and Quebec. MDA is the other leading problem, with 318 convictions and almost half in BC.

Overall, cannabis convictions in 1975 represented the second highest number in more than a decade, with only 1974 having more. Convictions in 1975 were 1,000 times the number in 1964.

Heroin convictions continued to decline to 511 convictions in 1975 from a high of 1,290 in 1973. Methadone seems to have stabalized at levels only one fourth the more than 80 convictions in 1971 and 1972.

But cocaine and LSD continue on the upsurge while MDA shows a continued decline. There were more than half as many cocaine convictions (289) as heroin (511) in 1975 as there were heroin convictions and three times as many LSD convictions (1,570).

Dangerous Drug Bureau keeps tabs on drug users

OTTAWA — In 1975, the federal government's Bureau of Dangerous Drugs had records on 133,639 known users of marijuana in the country, including the names of more than 28,000 added to the files during 1975.

Separate records also contains names of and information on some 13,927 known narcotic drug users, including 724 under the age of 20.

In addition, there are records on more than 20,000 known users in Canada of hallucinogenic drugs, almost 3,000 of them added in 1975.

Of the 3,000 added in 1975, slightly more than one-third were under 20 and most of the rest were under 25 years of age. Most were users of LSD (2,252), with the next largest group (538) being known users of MDA.

But the sheer numbers of known cannabis users (133,639, or about 0.6% of the total Canadian population), most of them added to the files within the past three years, has got to be staggering.

Of the 28,767 known cannabis users added to the files during 1975, 25,423 were male and 3,344 were female; 11,603 were under 20 years of age and 11,268 were between 20 and 24, with 3,528 between 25 and 29 and, at the other extreme, three being between 60 and 69.

Of the 3,992 under 18, two were 12 years of age, one was 11 years of age, 10 were 13 years of age, and 77 were 14 years of age.

In addition to those added to the bureau of dangerous drugs records for the first time as known cannabis users, there were some 4,026 males and 158 females arrested in 1975 who had previous cannabis records.

Some of the known cannabis users were either found in possession of or admitted using other drugs as well: almost 1,000 involving LSD alone or with other drugs; some 241 involving MDA; 248 involving heroin alone or with other drugs; 246 involving cocaine; and 310 involving PCP.

During 1975, some 577 previously known cannabis and-or hallucinogenic drug users were recorded as known users of other drugs, including 108 recorded as heroin users, 116 as cocaine users, and 136 as PCP (phencyclidine) users.

Of the 13,927 known users of narcotic drugs in Canada during 1975, some 10,792 were heroin users, 439 were opiate users, 1,077 were cocaine users, 931 were phencyclidine users, and 651 were users of synthetic narcotics.

Most of the information of users of narcotic drugs came from the police (9,336 reported), while 2,322 cases were reported by specialized drug treatment centres, and 1,576 came as a result of pharmacy sales records.

The number of known narcotic users has grown from 3,182 in 1966 to 10,250 in 1973, to 12,194 in 1974, to 13,927 in 1975.

Eleventh Canadian Cancer Research Conference

When it comes to tobacco. . .

'Personal choice largely humbug'

By Betty Lou Lee

TORONTO — People don't have the personal choice about cigarette smoking that legislators talk about, and politicians use this "choice" as an excuse for inaction, says an American cancer expert.

Children start smoking before they have balanced judgment and, by the time they mature, they are thoroughly hooked, says David B. Clayson of the Eppley Institute for Research on Cancer at the University of Nebraska Medical School.

"The idea that people can make a personal choice is largely humbug. One of the factors that leads to inaction is that many of the population and legislators are addicted."

He was one of 18 cancer researchers from five countries who took part here in a three-day symposium on environmental carcinogenesis at the Eleventh Canadian Cancer Research Conference.

Again, and again, speakers pointed to smoking as a known and preventable cause of cancer that continues to take its toll.

Dr Clayson said perhaps 45% of all male cancers in England and Wales are caused by smoking.

"This area, however, demontrates the general unwillingness to embark on effective cancer control and prevention programs. More progress seems to have been made in the control of carcinogens in food and drink, and in industry,. . . Despite its political unpopularity, the control of the cigarette smoking habit would make the greatest difference to the overall incidence of cancer in Western Europe and North America."

Takashi Sugimura of the National Cancer Centre Research Institute in Tokyo, agreed with Dr Clayson's pessimistic outlook on efforts to develop a safe cigarette.

Asked if people were being lulled into a false sense of security about low tar in cigarettes, he said the amount of tar was not related to tobacco's ability to cause mutations in cells.

Smoke condensates contain many strong mutagens, and there is a definite relationship between mutagens and carcinogens: Evidence mounts that if a substance is the first, it is also the second.

Dr Sugimara said the smoke condensate from one cigarette contains 370,000 nanograms of the cancer-causing hydrocarbon benzo (a) pyrene, yet the cigarette itself contains only 17 nanograms.

A. B. Miller, director of the epidemiology unit of the National Cancer Institute of Canada, said new occupational substances linked with lung cancer are being identified all the time, but occupational exposure accounts for only a small fraction of this type of tumor. "And what is more, one that is markedly influenced by cigarette smoking".

Dr Miller calculated that four years ago smoking was responsible for 80% of lung cancer deaths in Canadian men, and 22% in women. Now, cigarettes account for 46% of lung cancer deaths in women in this country, and our Eskimo women have one of the highest lung-cancer death rates in the world.

In view of the publicity about the dangers of smoking, this increase "can be regarded as one of the most striking failures of epidemiological knowledge to influence public policy to a sufficient extent to result in a reduction in one of the most important causes of premature mortality".

He thought modification of lifestyle was the key to controlling the important cancers in man.

Umberto Saffiotti of the US National Cancer Institute said it is politically more expedient to promote finding cures for cancer than to control factors that cause it. "It gives people hope, rather than more problems.

"I consider cancer as a social disease, largely caused by external agents which are derived from our technology, conditioned by our societal lifestyle, and whose control is dependent on societal actions and policies," said Dr Saffiotti.

Women risk oral cancer by smoking and drinking

TORONTO — Women who both smoke and drink alcohol develop oral cancer about 15 years earlier than women who don't use either drug.

Those who only smoke show a less dramtic earlier onset of mouth cancers, and those who only drink show no difference from abstainers and non-smokers.

Study results from the Roswell Park Memorial Institute at Buffalo, NY, are claimed to be the first conclusive evidence in humans that the combination of two chemical substances can produce cancer at an early age.

They were presented here at the annual meeting of the American Association for Cancer Research by Irwin D. J. Bross and Jean Coombs of the biostatistics department.

They compiled data on 145 white women with tongue or mouth cancer between 1957 and 1966, and 1,973 controls.

"It can be shown that exposure to both alcohol and tobacco can lead to onset of oral cancer 15 or more years earlier than would occur in women who do not use either," said Dr Bross. "Here is the first unequivocal evidence in humans that when two carcinogens act on the same target cells the effects seem to accelerate the carcinogenic process."

This could have important implications for detection of co-carginogens in the environment, Dr Bross said, for a mandatory system of reporting to a central registry could serve as an early warning for changes in cancer patterns, such as occurrence at an early age.

"When we add 500 new chemicals each year to our environment, it becomes increasingly likely that even if the separate chemicals do not produce cancer, the combination of two of them will. But there is little chance of discovering this from the kind of laboratory tests which are now conducted."

Irwin Bross

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Alcohol campaign too little, too late

CANADA'S FEDERAL government is finally fulfilling its three-year promise to get involved with the country's spiralling alcohol problems.

But, based on Health Minister's Marc Lalonde's pronouncements at the INFORMACTION conference (see Page 1) there's little to get excited about . . . at least for the moment.

Mr Lalonde provided the skeleton for a proposed media campaign, to get underway this fall, which is apparently designed to stimulate a national Dialogue on Drinking.

Mr Lalonde described the publicity program as a sincere attempt to evoke two-way communication between governments and the people they represent.

This may well be one of the program's objectives.

However, we'll venture a guess that the prime objective of the campaign is designed to catch votes. At this stage, the campaign sounds as if it'll be politically expedient, but little else.

Surely, after three years of relative nothingness, the Federal government, through its Non-Medical Use of Drugs Directorate (Non-MUDD), could have come up with something a little more convincing.

Non-Mudd has had a rather dismal record in its six years of life. With respect to the alcohol mandate it developed three years ago, it has been batting zero.

The use of multi-media techniques to cut into growing public consumption of alcohol has already become a highly visible activity of health ministry communicators in Saskatchewan and Ontario and to a lesser extent, in Manitoba and Alberta.

Of course, as Mr Lalonde noted in his address to the CFADD meeting, media campaigns in themselves cannot be expected to solve too many alcohol-related problems, in that they do not significantly alter attitudes and resulting behavior.

But publicity campaigns, such as those now operating in Saskatchewan and Ontario, can create a climate of awareness in the general population that can be expected to translate into legislative change.

At this moment, it is unclear what the specific objectives of the Dialogue on Drinking campaign are designed to achieve . . . other than government identity with concern over alcohol problems in Canadian society.

Mr Lalonde indicated that the provinces and territories support the federal plan and have, to a certain extent, been involved in its development.

To what extent the provinces *actually* support the program will depend largely on whether or not the national campaign blends with the provincial awareness programs.

Provinces that have little going for them because of money shortage will not doubt welcome the federal initiative on the grounds that something is better than nothing.

But some other provinces may well resent the feds' attempt to infiltrate what is largely a provincial jurisdiction. Further, these provinces might wish to literally keep the federal program out, realizing it would interfere with their own programs by creating message and media clutter.

We cannot argue with the Federal government's desire to achieve federal-provincial coordination, Non-MUDD's stated goal for several years. We do, however, question the fashion and the timing of this cooperative effort.

Hindsight is always a blessing.

Consider . . . had the Federal government developed a national policy respecting alcohol when it was expected to do so a few years back . . . had the Federal government initiated meetings with provincial representatives with an objective of designing a national information/ publicity program before the provinces moved ahead on their own steam . . . we may now have been much further down the road in terms of moving the general population towards more reasonable laws and drinking behavior.

With reality being what it is, all we can now hope for is that Mr Lalonde and his staff have more, much more, in mind that the Dialogue on Drinking program.

There can be little doubt that Canadian society as a whole is more concerned than it has been for a considerable number of years with growing alcohol abuse.

The Federal government would be foolhardy not to demonstrate its interest with a variety of initiatives while the momentum is gaining.

GS

"Wonder why they never ask us to do a beer commercial?"

Letters to the Editor

More letters — page 12

Cannabis issues

Dear Sir:

I found the letter of André McNicoll in your April issue quite interesting, as well as the disclaimer at the end by the editor to the effect that the views of the staff do not necessarily reflect the views of the Addiction Research Foundation.

I too had assumed that it was official ARF policy to be anti-every chemical in the book, from heroin to alcohol and coffee, with the exception of marijuana, which is praised, headlined, and prattled about favorably in every article.

I defy you to go back through the last several dozen issues of The Journal and to find one — just one — article which gives a rather unfavorable view of marijuana, with editorial expressions of joy over some state voting against legalization (mistakenly referred to as decriminalization) of the stuff. Such unanimity of sentiment, I submit, can scarcely be accidental. Surely it is either official policy or an article of faith among so many of your staff that for all practical effects, it is de facto official policy.

And such a stance is not merely inconsistent, it is schizophrenic. How on earth can you favor such an obviously potent drug about which so little is reliably known. Here I must point out to you that there is a remarkable innocence on the part of your staff, who are obviously journalists devoid of scientific training, with respect to the research projects which show favorable or unfavorable effects of cannabis use. It is pathetic to behold the joy with which they fling themselves on the 'pro' studies, and the helpless scepticism and hostility with which they greet the 'anti' studies. Could it be that they need some more personal form of reassurance? And is this attitude nothing but hypocrisy in those supposedly dedicated to a dispassionate investigation of drug addiction?

In trying to understand this wierd split, I have been helped by my knowledge of Canada — some four years there, for two as chairman, Psychology Programs, Atkinson College, York University — and my knowledge of addiction — three years, Federal Narcotics Hospital, Lexington, Ky.

To be pro-marijuana is to be anti-establishment and especially anti-American establishment. It has been, and is, fashionable to be anti-American; indeed, I left because I could no longer tolerate Canadian provincialism and xenophobia. I submit that a sizeable number of your staff cling to what can only be called 'cannabisism' because they were members of the Young Rebels of the 1960's and early 1970's, and have not yet matured to a positive view of the world. They apparently can perceive an identity only when it is against something, and marijuana is the youth cult's 'anti-' symbol.

Surely we can expect more mature, sophisticated and scientifically-minded thinking from an institution supposedly committed to sound understanding of a worldwide health problem. Surely you can take the politics and juvenilism out of what might be an interesting paper.

Stanley A. Rudin, PhD
Hot Springs
South Dakota

Editor's note:

Dr Rudin's contention that The Journal staff seizes with glee upon any scrap of evidence praising the effects of marijuana, and deliberately suppresses items focuing on the drug's ill-effects is a gross distortion.

(continued on page 12)

Backgrounder

Who are the trainees?

Third and concluding part of a series on national training initiatives.

By Milan Korcok

FIVE YEARS ago, the act of treating a drug user in trouble was at best an imprecise craft.

There were precious few guidelines about what to do and how to do it. Training was a matter of serendipity and seat of the pants.

Well, now look at it!

The National Institute on Drug Abuse estimates that there are more than 30,000 people working in the current network of drug abuse treatment/rehabilitation and prevention services.

The federal budget for manpower and training is up at the $10 million level and considered parsimonious.

Across the country, ex-addicts, masters of social work, cops and clergymen are rubbing shoulders in classrooms, probing the mysteries of "empathy understanding" and "problem solving" — among other things.

To thousands, drug abuse treatment and counselling has become a career, with all the jostling for status and security that the world "career" implies.

There are many who resent the way these career imperatives have taken shape, who look back longingly on the days when instinct, intuition, and the accident of "having been through it" were the only prerequisites one needed to work in the field. But it was inevitable that as the treatment and rehabilitation needs grew and diversified, and as treatment programs had to prove their dollar value, improvisation would give way to structure and form.

First it was the NIMH to recognize the need for building and maintaining an adequately-trained manpower pool for the growing numbers of programs across the country. Then, with further refinements of resources and needs, NIDA set up the National Training System, intended to provide the structure and mechanism for taking training materials and methods out to the field. (See Backgrounders of **The Journal**, May and June issues). The scope of the system is broad.

Developmental grants provide professionals and paraprofessionals drug program training options in either two or four year colleges.

Research Fellowships provide for pre- and post-doctoral fellowships for psychological and biomedical students.

The Physician Education Program seeks to improve medical student training in the drug abuse field and improve the teaching and curriculum design at medical schools.

The Career Development Center stimulates development of non-traditional education models for paraprofessional and ex-addict trainees. The emphasis here being on competency criteria rather than academic experience.

Then, in July, the NTS undergoes another refinement as the Regional Resource Centers and Regional Training Centers consolidate. The point of this being, to strengthen the regional link between the states and the feds, giving the states more influence over what is taught to whom.

This regional training function of the NTS is perhaps its most critical component because here is where the balance between state and fed activities is most delicate, and where the interface between professional and "other" — sometimes called "paraprofessional" is most apparent.

Back in 1971, when the idea of a national system was picking up steam, the various regions were putting together their own individual training programs, responding directly to the needs expressed at the community level. At this point, a typical group of trainees might include high school drop outs, ex-addicts, PhDs, and MDs. Obviously it was not easy, using traditional training techniques, to deliver a course that would be meaningful to all these groups at the same time.

And so, shifts in training ideology became necessary, with a growing reliance on federally-produced training packages that could be applied more broadly and that used innovative methods to hold the attentions of the audiences.

Role-playing, one-to-one confrontations, audio-visual tools became standard training delivery mechanisms.

A recent NTS status reports says: In 1975-76, manpower training is no longer a situation in which treatment personnel are being taught by research staff. Training has become an art: identifying the learner and his needs; strengthening the trainer and improving his methodology; making training widely available at many delivery sites.

In 1974, the Regional Training Centers were developing up to 95% of course materials, the National Drug Abuse Center 5%. In fiscal year 1976 the RTC-produced materials were down to 23%, NDAC up to 77%.

This is how that 77% breaks out in terms of trainee participation. In 1976, 39% of trainees are taking the short-term counselling course in which they learn and practice the elements of emphathetic understanding and problem solving. This remains the most popular of the courses.

Fundamental Facts and Insights (a general introduction to drug abuse for a variety of general and professional audiences) are being taken by 16% of the participants.

Training of Trainers (designed to increase trainers' skills in systematic course design and delivery) are taken by 13%; Making A Difference With Youth (for those working in primary prevention) by 8%; and Methadone Treatment Managers (administrators with overall responsibility for methadone treatment clinics) by 1%.

The other 23% are taking courses prepared by the regional centres themselves. These courses involve such items as psychology of drug abuse, program development, counselling and transactional analysis, clinical program administration, sexuality issues in treatment, single state agency courses, Spanish language counselling, and several others.

During 1973 and '74, when training budgets were at their peak, all of the RTCs were able to use a lot more initiative in meeting local needs.

Tom Cahill, director of the Miami centre notes that two years ago, when he had three times the budget as well as three times the staff (15 full-time in 1973 vs. five full-time now), his centre was marshalling training resources of many individuals throughout the University of Miami — experts in law, business administration, pharmacology, psychology. At one time he had a resource pool of 100 individuals who could be counted on to some degree to help in preparation of specialized courses.

But tightened federal budgets took care of that local initiative.

"We still have a demand for such training topics as funding, personnel management, community organization, etc.," says Dr Cahill. "But lately we haven't offered these, because we haven't got the money."

A particularly imaginative course to fall by the wayside was one developed for Spanish-speaking cultures, one that could be used in the heavily Spanish areas of South Florida as well as for the many visiting drug agency representatives from Latin American countries.

This was not a translation of any other existing course, but one constructed with the Latin lifestyles clearly in mind. For example, because of the strong family ties that characterize Spanish communities, more emphasis would have to be given to dealing with the whole family, in a therapy situation. This would involve bringing in not just the individual drug user, but the parents, the brothers and sisters, even the grandparents.

Whether or not such local initiatives will once again be revived under the new regional emphasis is a point to be watched.

But not only are courses changing, so are the students.

In the fiscal year 1974, the regional training centres worked with 3,010 individuals, each program averaging 753. In fiscal year 1976, more than 4,410 (average 883 per centre) will have been trained.

Who are these trainees?

In the first half of 1976, 62% were White, 23% Black, and 13% were Mexican Americans, Cubans, Native Americans, Puerto Ricans, Asian Americans, and Latins. Actually, considering the national population distribution (White 86%, Black 11%, and other groups 3%) the White trainees were somewhat underrepresented.

The largest groups of trainees were those involved with treatment functions (counselling, therapy, social work of various types). These accounted for 39%.

The next largest occupation group, one that has grown significantly, is educational, which accounted for 26% of trainees.

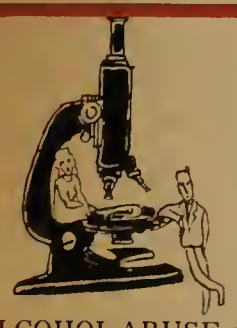
Among the rest, 9% of trainees were people from other social services, 6% were health and medical workers, 13% from business and management circles (most from single state agencies), 4% from criminal justice and corrections, and marginal numbers from the clergy, research and evaluation, and vocational rehabilitation.

One of the major concerns to training system planners is the shifting proportional breakdown that sees professionals taking over more and more training slots and paraprofessionals comparatively fewer: In 1975, 43% of trainees were professionals and 35% paraprofessionals (the rest were full-time students). By 1976, this ratio had shifted to 46% professionals and 29% paraprofessionals.

Does this mean that the emphasis on structure and academic training is turning off some of the paraprofessionals? Perhaps. It could also mean that many paraprofessionals are becoming professionals by acquisition.

But then the question still remains: In treating a drug user who has run into trouble, who is the professional? Is it the MSW from one of the Big Ten, or is it the graduate of Daytop, trained in group confrontation?

Until this is sorted out, it seems the granting of credits will have but limited impact on the career paths of drug abuse program trainees.



Inside Science

This month Dr Denis Lander, a psychologist with the Addiction Research Foundation of Ontario, discusses behavioral modification in drinking.

ALCOHOL ABUSE may be viewed in different ways. The behavioral view eschews interest in the unobserved and rather mysterious state labelled "alcoholism" in favor of examining what excessive users of alcohol actually do. Hence, this approach focuses on the drinking behavior itself. The promise of this approach is that an understanding of the determinants drinking will provide the means to modify it. And it does not seem unreasonable that having the means to change drinking patterns would be useful in helping those who harm themselves and others with their drinking.

However, we must be very careful to distinguish between the promise of this approach and its actual accomplishments to date. Too often its proponents have left the impression that the only question which remains undecided is who gets the trip to Stockholm. Some solid progress has been made, but there is still an enormous amount to be learned about drinking and related behaviors; we have barely scratched the surface. In particular, we must face the fact that drinking is not a simple, unitary, independent response, something like a knee jerk. It would be more realistic to regard it as a complex set of behavioral sequences that interact with other responses and features of the situations in which they occur.

One thing we have learned is that the basic principles governing drinking appear to be essentially the same as those governing other behaviors. For example, it is now well established that the probability of drinking is affected by its consequences; favorable consequences of drinking tend to increase its probability while unfavorable consequences have the opposite effect under controlled conditions. It is also clear that drinking depends upon characteristics of a learned behavior which is maintained and controlled by events in the environment. This has been known for quite some time and is hardly surprising. But the importance of these demonstrations is that we already know a great deal about the way these principles apply to other behaviors. This means that drinking is amenable to a powerful and well-established form of experimental analysis.

It follows from what we know about the control of behavior that it will be possible to manipulate an individual's environment in a way that will produce and maintain a decrease in the frequency of drinking. In other words, it is theoretically possible to train excessive drinkers to become controlled moderate drinkers.

But, here we must return to our distinction between the promise and the accomplishment of the behavioral approach. While we have good reason to think that training in moderate drinking will one day be an effective treatment alternative, a satisfactory set of procedures for achieving this is simply not available today. And, of course, there are no satisfactory techniques for producing abstinence. These must remain in the realm of 'promise', where they may remain for a good many years yet.

However, there is evidence that these are not empty promises. First, we know it is possible. Careful documentation over the last 14 years has shown that a small proportion of 'gamma alcoholics' achieve controlled moderate drinking without professional assistance. Second, a number of experimental studies in closed clinical settings have demonstrated that moderate drinking can be maintained while a particular set of contingencies is in effect. These observations are seductive because they show the *possibility* of controlled drinking so clearly. But there is a great deal of difference between controlling events in a closed laboratory-like environment and in the highly complex real world. This is the challenge to which behavioral scientists are currently responding.

Ottawa plans 'Dialogue on Drinking'

(continued from page 1)

ate social contacts — families, friends and workmates, some of whom may not be so firm in their views or careful in their habits;

• "We" want to address an audience that will be sufficiently concerned to become involved in devising solutions to alcohol problems from a base of sound knowledge at the community level;

• "We" want our information campaign to provoke the public to make governments aware of their views about the most appropriate solutions to alcohol problems.

In other words, Mr Lalonde said, his department wanted public policy to be truly reflective of the views of responsible and thoughtful citizens.

Three phases are planned for the Dialogue on Drinking program. The first will begin this fall, the second next spring, and the third in the fall of 1977.

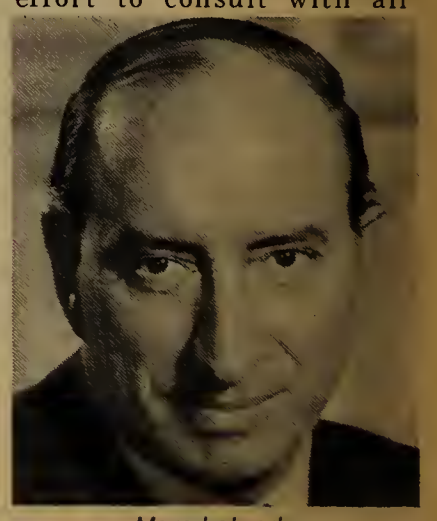
Mr Lalonde did not indicate how much money was being allocated to the program.

The first phase of the program will discuss facts related to the five major problem areas identified. The second phase will elaborate on actions being taken to deal with the problems in the hope this will stimulate dialogue between people and involvement at the community level. The final phase will deal with policy alternatives and encourage reaction to possible government response.

Mr Lalonde said the theme Dialogue on Drinking would thus be a sincere attempt to evoke two-way communication between governments and the people they represent.

Such an approach, he added, calls for governments to provide instructive knowledge through advertisements and booklets and pamphlets, to respond adequately to the for information, and to respond adequately to the dialogue which results.

Mr Lalonde said his department had made a deliberate effort to consult with all



Marc Lalonde

Canadian provinces and territories about Dialoguc on Drinking.

He reported that all support the concept of two-way communication with the public, but some understandably want to see the final messages that are selected before deciding upon their degree of participation.

Mr Lalonde said his department will continue to offer the program to the provinces and will share with them the knowledge gained from response to the campaign in an effort to secure a united front in dealing with alcohol problems.

To determine how media can best be used as part of a long-term — perhaps five years, perhaps a generation — and total approach to combat alcohol abuse, Mr Lalonde said his department studied several public information programs.

He said Alberta, Saskatchewan, Manitoba and Ontario, in particular, provided knowledge about public programs they have operated and the knowledge gained has been used to plan the federal campaign.

Biomedical research effort weighed

By Charles Marwick

WASHINGTON — Improved mechanisms for coordinating research in alcohol and drug abuse are called for in a report of the President's Biomedical Research Panel handed to Congress on the last day of April.

In an obvious effort to get higher visibility for the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA), the report recommends a presidentially appointed three-member panel, to supersede the present ADAMHA panel members who are appointed only at the departmental level. Two members of this panel should be professionals with research competence in mental illness or substance abuse, the report says.

The President's Biomedical Research Panel was established by Congress almost two years ago to review the government's effort in biomedical research. Since January, this seven-member panel, chaired by Franklin P. Murphy — a doctor and president of the Times-Mirror Company of Los Angeles and a former dean of the school of medicine at the University of Kansas, held almost monthly public hearings.

The resulting final report points to weaknesses or failures (as well as successes) and in the light of these recommends policy for the future.

The bulk of the huge report, which has only become generally available this month (July), deals with the biomedical research effort in the US in general and the way it is organized.

One part of this review discusses substance abuse and is therefore of particular interest to readers of **The Journal.**

The panel assessed the major advances of the past five years in the field of neurobiological science. Among those they cited were:

• The isolation of opiate receptor sites and the identification of a naturally occurring morphone-like substance in the brain;

• The development of analgesics with relatively low abuse potential such as pentazocine;

• The fact methadone is now accepted as a major component of the treatment of chronic heroin addiction and the emergence of the long acting form of methadone — LAAM — which seems to overcome some of the problems with the use of methadone;

• The development of narcotic antagonists for the treatment of chronic opiate addiction;

• The demonstration that alcoholic cirrhosis may be induced in animals;

• The elucidation of the active principles of marijuana, the tetrahydrocannabinols and their synthesis, has allowed the precise control of marijuana dosage and so led to linking accurately the effects of this drug on behavior;

• In tobacco smoking, there has now been found a genetically mediated enzyme mechnism which plays a role in the production of emphysema and the activation of the carcinogenic compounds of tobacco among smokers. The finding may explain why some heavy smokers develop lung cancer or clinically significant emphysema more speedily than other, equally heavy, smokers; and,

• A new class of barbiturates known as the benzodiazepines have been developed which form a new class of drugs for the treatment of severe tension and anxiety and which are not as subject to abuse as the older barbiturates. These newer agents have also been successful in treating once-fatal delirium tremens. The panel describes the development of these agents as a major advance in clinical psychopharmacology.

The panel's report also outlined some specific areas that would be particularly rewarding for further research into the effects and control of substance abuse. Among these are:

• The correlating of opiate dependence in humans with the long-lasting changes in brain and neural function that have been seen following chronic opiate exposure in animals;

• Studies on the neurochemical, behavioral, and metabolic factors involved in the development of tolerance to marijuana and the hallucinogens;

• Further study of the psychological factors in substance dependence should lead to more effective treatments of addiction;

• New therapeutic agents based on the systematic evaluation of the cannabinoid compounds may be developed and could provide new types of analgesics, psychotherapeutics, antiemetics, anticonvulsants, and specific immunosuppressants;

• The underlying mechanisms of the effects that marijuana produces on the heart, the endocrine, the immune and the behavioral systems is unknown. Studies must be done to evaluate the risks of marijuana use over the long-term although no apparent serious health hazard from the casual use of marijuana has emerged;

• Methods of predicting a drug's abusc potential might be developed and coupled with methods for assessing the cost-to-benefit ratio of an agent and this would permit a new drug's abusc liability to be weighed against its possible clinical benefits;

• Promising new treatments for chronic alcoholism such as the use of lithium carbonate and newer ways of administering disulfiram arc being developed. In the next few years, thc full value of these approaches could be clarified;

• In epidemiology, sophisticated case-finding and assessment of incidence and prevalance of multiple drug abuses are possible. Thus recurrent changes in abuse will not in the future be labelled as "epidemics" but be seen in their proper perspective in the context of the total problem. This, in turn, will lead to a more valid assessments of various treatment programs; and,

• Finally, the report noted, there are new experimental methods in which normally reluctant animal ethanol drinkers can be transformed into voluntary chronic alcoholics by purely environmental manipulation. This carries the clear implication that human ethanol overindulgence may also be catalyzed by chronic environmental situations.

To implement such studies, however, the report noted there needs to be a high level of science administration at ADAMHA. The agency has lacked this capacity and this has impaired biomedical advances in, for example, the field of alcoholism. A closer association with the National Institutes of Health (NIH) will improve the coordination of the scientifically related functions of ADAMHA, the panel maintained.

The panel also called for long-term funding of research. Two or three-year funding patterns are counterproductive, the report stated. One way of obtaining greater stability in funding would be to commit funds a year ahead instead of, as at present, a year behind the support of a particular research study. Less time would be spent by scientists in reapplying for funds to continue their work and more time would be spent actually getting the work done, the panel report said.

Whether the recommendations and avenues for further study contained in this report will be implemented is of course another matter. While the full impact of the report is only now beginning to make itself felt, the initial reception in Congress is negative.

Senator Edward M. Kennedy (D-Mass) has indicated he is dissatisfied with it as being too research-oriented. The report has not gone deeply enough into the relationship between research and results, he says.

"The research community and the public investment in it have reached the point where a careful examination of basic principles is in order," he declares.

There is little question the report is in fact research-oriented. This could hardly be otherwise. Five of the panel's seven members are research scientists working in leading medical institutions. However, some members of Congress, at least, expected the report to bridge the gap between research and the delivery of health care services.

The report describes and, to a large extent, critically but constructively examines the administration of the overall biomedical research effort that the government underwrites. It does not offer suggestions as to where this effort fits into the nation's health care system.

It could fairly be said this was beyond the panel's scope. Biomedical researchers engaged in the acquisition of knowledge about the biological world cannot be primarily concerned with the ultimate use of such knowledge. That, the report says, in effect, is not their department.

This may be true. But the funding of science in the US (and really in any country) is predicated on results, not just the acquisition of knoweldge even though the results depend on knowledge. Sooner or later scientists conducting research supported by public funds will have to come to grips with the issues now being raised in Congress in its discussions of this Biomedical Research Panel's report.

Editorial board member attains government post

TORONTO — Eugene LeBlanc, a member of The Journal's Editorial Board, has been appointed Director of the Research Branch of the Ontario Ministry of Health.

Dr LeBlanc, who took up his new position on June 7, was formerly assistant head, Research Division, and scientist, Biological Studies, of the Addiction Research Foundation. In addition, he holds an assistant professorship in the Department of Pharmacology at the University of Toronto.

Eugene LeBlanc

Dr LeBlanc received a PhD in pharmacology from the University of Toronto in 1973, having completed studies in biochemistry for a BA at Queen's University in 1964.

Dr LeBlanc's research interests lie in the general field of behavioral pharmacology, with emphasis in toxicology. Although the majority of his research has been in the field of alcohol and drug dependence, recent interests include occupational and environmental hazards. In addition, has has wide interests in the field of social policy development.

Next month

The Journal will present extensive coverage of INFORMACTION 1976, the eleventh annual conference of the Canadian Foundation on Alcohol and Drug Dependencies, held in Toronto, Ont., June 20-25, and hosted by the Addiction Research Foundation.

Work in Progress in Alcoholism

Gary Seidler reports from the NCA meeting, Washington, D C

Senator Hathaway charges

US gov't perverts health priorities

WHILE THE US celebrates its 200th birthday with plastic liberty bells and red-white-and-blue color coded Fords, nine million alcoholic Americans were not invited to the party.

"I live in a country where, sadly enough, the Federal government has held great hopes of overcoming alcoholic dependencies while dashing those hopes through impoundments, budget cuts and fiscal and programmatic strangulation," Senator William Hathaway told the opening session of the conference.

In a blistering attack on the Federal government's failure to combat alcoholism, Sen Hathaway took steady aim at the Administration's penny-wise and pound foolish attitude.

(Sen Hathaway is Chairman of the US Senate Subcommittee on alcoholism and narcotics.)

"If importing or manufacturing alcohol was a crime, and people committed that crime — as they certainly would — then alcoholics would probably be as high a priority for Ford (President, Gerald) as drug abuse. Perhaps even higher since there are conceivably 20 times as many alcoholics as there are drug addicts.

"... don't misunderstand my intentions. I do not for a minute begrudge drug abuse treatment its current level of support from this Administration.

"Rather, I believe its peculiarly selective support must leave the White House open to serious charges of government by catchword ... of perverting health policy priorities to the cause of simple-minded political expediency."

Without the support of the Administration, Sen Hathaway said, it's become difficult, if not impossible, to generate a broad base of support for programs to satisfy all the research, prevention and treatment needs in this critical health policy area.

"We bandy about numbers of alcoholics and dollars of lost productivity and arguments about social effects, but too many of the country's top decision-makers think of it as useful in the next primary election."

Sen Hathaway accused the government of indiscriminate budget cuts for some health areas and blatantly political over-emphasis on others.

He said alcoholism treatment, prevention and rehabilitation have not alone been subject to "slash and burn" budget policies, "but it's a pretty good example of their indiscriminate style.

"Ever since we committed ourselves to federal support at the beginning of this decade, the Federal government has been squabbling with itself over how this program is going to run.

"Meanwhile, under the smokescreen of impoundments, recessions and hastily contrived block grant proposals, the key decisions are made by low level functionaries with red pencils and pocket calculators."

Research, Sen Hathaway continued, is consigned to "a sort of biomedical Siberia in a falling-down hospital".

Effective programs for drunk drivers are red-lined out of existence.

On a more positive note, Sen Hathaway praised recovered alcoholics who continued or resumed their former careers, and those who turned to new careers as "selfless soldiers in the war against the disease.

"For them, I have nothing but admiration, respect and a touch of awe. They are badly paid. They are often forced to work in substandard facilities. They are subject to the arbitrary whims and fancies of those who control the sources of their funds ... and yet they do their work compassionately, with warmth, with understanding."

Introduce legislation

Alcoholic's rights need definition

THE DAILY rights of alcoholics need definition, according to a ranking official of the National Council on Alcoholism.

Apart from the areas of public intoxication and commitment, there has been no definition of the everyday rights of the nation's 10 million alcoholics and the 40 million family persons they affect, Allan Luks, executive director of the NCA's New York City affiliate, told the conference.

"The pressures on law and legislation to respond and define the alcoholic's rights are increasing as alcoholism's stigma lessens."

In child custody cases, Mr Luks pointed out that a recovered alcoholic does have the right to petition for reopening of a custody determination, but that courts generally don't want to disturb a settled family.

"The question is whether the recovered alcoholic's rights, as well as the children's, are being properly protected," he added.

On the issues of employing recovered alcoholics, Mr Luks said there are federal regulations prohibiting discriminatory practices in not hiring recovered alcoholics, but there is no legislation mandating nondiscriminating practices at the state level.

Among areas needing attention are domestic relations, jobs, confidentiality, criminal law, health and fire insurance, public assistance, licenses and commitment.

In the area of domestic relations, Mr Luks said, "alcoholism's resulting behavior, not the illness itself, is grounds for divorce. While the spouse doesn't have to forgive acts of mental cruelty, adultery, etc.," he asked, "should some exception be made where the offending mate was an active alcoholic and is now recovering?"

Pull-out Section

Teenage alcoholism is threatened by complacency

COMPARISON OF public opinion with actual levels of teenage drinking provides a disquieting insight into the fact that drinking by young people appears to be increasingly acceptable to both youth and adults generally.

This complacency in the face of an imminent problem could point toward a major increase in alcoholism in the future, not only for adolescents but for persons of all ages, a biostatistician told the conference.

Lilian St Clair Blackford arrives at this conclusion from a series of nine annual surveys of high school students' alcohol and drug habits in San Mateo County, an affluent suburb of San Francisco.

The number of occassions at which young people (Grades 7-12) consume alcohol has increased steadily and dramatically since 1968, according to the studies.

"This may have conditioned the public to accept the use of alcoholic beverages by teenagers on a wide variety of occasions as appropriate."

Ms St Clair Blackford pointed to another problem, probably more ominious than the actual increase in drinking by adolescents.

Beginning in 1973, she said, there appears to be a levelling off of alcohol use. But the fact the situation might be stabilizing could lead to a dangerous complacency, "even at this very high level.

"Perhaps the situation is no longer epidemic or atypical and the possibility of just accepting it and considering it endemic is appalling."

The San Mateo studies show that alcohol consumption by students increased from 65% (on one occasion) in 1968 to 86% (on one occasion) in 1976.

The percentage of students who reported use on at least 10 occasions — defined by the studies as "significant use" — increased from 25.4% in 1968 to 51.6% in 1976.

The pattern of alcohol use is even more dramatically illustrated by median use. A student who uses alcohol on the median number of occasions can say that half the "guys" drink more frequently than he, and the other half less frequently.

The median for Grade 11 male students increased from 3.7 occasions in 1968 to 25.9 occasions in 1976. Girls drink on fewer occasions, year for year, but the median increased from 2.4 occasions in 1968 to 18.7 occasions in 1976.

Research boost is 'heartening'

VOLUNTARY GROUPS in the alcohol field should not develop too great a dependency on federal financing because this dependence may threaten their very existence and independence.

In a luncheon address, the Hon. Paul G. Rogers, chairman, House of Representatives Sub-Committee on Health and Environment, also expressed concern over the committment of large grants and contracts to groups not engaged in prevention and treatment.

At the same time, Mr Rogers welcomed the increasing wave of interest in strengthening the research capabilities of the National Institute on Alcohol Abuse and Alcoholism.

Mr Rogers referred to the recent authorization of $6 million per year for fiscal years 1977, 1978 and 1979 for national alcohol research centres as "a tremendous breakthrough".

He was also heartened by the conclusion of the President's Biomedical Research Panel which concluded, after a 15-month study, that the NIAAA must receive increased research funds since the percentage of its budget now devoted to research is the lowest of any federal institute.

Alcoholism treatment now a nursing specialty

A new aggressive approach

THE EVOLUTION of the nursing profession from the obedient shyness of its early days to the present "spirited independence and specialization" has opened a new and aggressive approach to the treatment of alcoholism as a nursing specialty that can operate fairly independently.

In fact, according to Evelyn Cohelan, chairman of the department of nursing at George Mason University, Fairfax County, Virginia, nursing people working in alcoholism "represent a very relevant and important speciality in nursing".

In the not too distant past, Dr Cohelan reminded her audience, alcoholics were not recognized as patients about whom nurses should be concerned.

"Of course, we cared for many people whose bodies and minds were damaged by alcohol consumption, but when they entered hospital they were labelled according to what was damaged and alcohol was given only passing attention."

While the situation today is not all that different, health professionals "are trying to hasten the coming of the day" when they have the skills to deal with alcohol abuse so that damage to minds and bodies can be prevented.

"With the development of public health systems," Dr Cohelan remarked, "nurses acquired the skills necessary for their participation.

"And many nurses began to define their role as one of leadership.

"Nurses have sustained this view of themselves as leaders, moving on to new challenges as the old ones are made manageable."

Annual meeting of the Ame

Contributing Editor Milan Korcok reports

Psychiatrists knowledge of drugs 'de

TRANQUILLIZERS AND antidepressants may be the psychiatrist's chief pharmaceutical aids, but a recent survey done at Albert Einstein College of Medicine at Montefiore Hospital in the Bronx, suggests psychiatrists' knowledge of these psychoactive drugs is grossly deficient.

Richard M. Gottlieb, clinical instructor of psychiatry, told the meeting the psychiatrist is ill-prepared, psychopharmacologically, to function optimally in the setting of the medically ill, and is likewise ill-prepared to be a teacher of his medical colleagues.

The psychiatrist should be a "model" for the use of psychotropic drugs and a teacher for his non-psychiatric medical colleagues, said Dr Gottlieb. After all, psychoactives are "his" drugs.

Yet, results of a 29-item questionnaire presented spontaneously to three medical groups were sobering indeed. (The groups were interns and residents at the end of their training year in medicine; post-residency fellows in consultation and liaison psychiatry training programs and other attending physicians at the end of their training year in psychiatry; and medical students during their clinical clerkships in psychiatry and medicine.)

The survey covered clinical indications for use, basic pharmacology and physiology, and toxicities and side effects of the commonly-prescribed benzodiazepine, "minor" tranquillizers, and tricyclic antidepressant drugs.

Material focused on when to prescribe drugs, choice of routes of administration, dosage schedules, drug interactions, and reasons for the exercise of caution in their use.

Results of the survey showed the general level of knowledge of all three groups in respect to physiology, pharmacology, and side effects of benzodiazepines was low. None of the groups could achieve better than 39% correct answers.

When it came to depression and the tricyclic depressants, psychiatric staff scored considerably better than either the medical house staff or medical students. The psychiatric students scored in the 80s on questions regarding clinical diagnosis and indications for use, physiology and pharmacology, and side effects.

The three groups scored similarly for questions concerning anxiety and the benzodiazepines — 73% for clinical indications, 35% for physiology and pharmacology, an effects.

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A need for vigilance

Long-term use of Antabuse has many dangers

THE POSSIBILITY that long-term use of disulfiram (Antabuse) may induce neurological, gastrointestinal, or even cardiovascular side effects emphasizes the need for vigilance by physicans prescribing this drug, says John Rainey, assistant professor of psychiatry at Wayne State University.

Such vigilance should involve mental status and neurological examinations, Dr Rainey told the meeting.

Dr Rainey's concern about chronic disulfiram use arises from studies done on the toxicity potential of carbon disulfide, one of the major metabolites of disulfiram.

Surveys of viscose rayon workers, who in the course of their jobs are normally exposed to consistent levels of carbon disulfide, showed increased prevalence of psychopathological, neurological, cardiovascular, and gastrointestinal disorders. The exposed workers showed at least three times the prevalence of arteriosclerotic cardiovascular disease when compared to controlled groups of workers in the same factory not exposed to carbon disulfide.

The workers described in these studies were exposed to 30 to 60 mg of carbon disulfide as an average daily dose. Dr Rainey calculates that individuals taking 125-250 mg of disulfiram per day would presumably absorb approximately the same levels (disulfiram is 50% carbon disulfide by molecular weight) except that the rayon workers are exposed only eight hours a day, five days a week. Disulfiram users take this drug for prolonged periods.

Dr Rainey says there are differences in the absorption rates and patterns of carbon disulfide in the atmosphere and in the form of disulfiram.

Atmospheric carbon disulfide is rapidly absorbed by the lungs — absorption and exhalation reaching equilibrium in five to six hours, while the exhalation produced by the metabolism of disulfiram requires five to six days.

Consequently, says Dr Rainey, severe disulfiram poisoning should more closely approximate chronic, moderate-to-severe carbon disulfide poisoning, "and the effects are more likely to be irreversible".

Dr Rainey stresses that the clinical, biochemical, and pathological neurotoxic effects of disulfiram are strikingly similar to those of carbon disulfide.

Both ingestion of disulfiram and exposure to carbon disulfide are associated with depression, lethargy, loss of libido, psychosis, various fluctuating neurological signs, ataxia, incoordination, and peripheral neuropathy.

If carbon disulfide is responsible for the findings of disulfiram neurotoxicity, says Dr Rainey, then treatment with this drug could result in some of the other toxic effects. A disulfiram overdose might result in parkinsonism, choreoathetosis, thalamic syndrome, and endocrine abnormalities, as well as increased incidence of arteriosclerotic cardiovascular disease.

For the physician administering disulfiram, efforts to detect and prevent side effects might be expanded beyond the normal clinical signs and symptoms already recognized, says Dr Rainey.

Two additional neurological tests easily administered involve periodical examination for corneal anesthesia (often observed following direct contact with carbon disulfide vapors) and detection of alterations in the size of the blind spot.

Blind spot enlargement is almost invariably associated with the presence of a peripheral neuropathy in workers exposed to carbon disulfide, and optic neuritis has been reported in patients taking disulfiram.

In future it may be possible to use carbon disulfide concentration measurements in exhaled air to predict disulfiram side effects, and any predisposition to arteriosclerotic cardiovascular disease may be predictable by routine determinations of serum lipoproteins, cholesterol, and tryglyceride levels, says Dr Rainey.

Reports of Antabuse depression debunked

DEPRESSION AND organic brain syndrome are the two most-commonly reported unwanted reactions to disulfiram (Antabuse).

But recent tests reported to the meeting indicate such reactions could be more readily attributable to certain vulnerabilities among some of the patients than to the drug itself.

Martin H. Keller, of the Medical University of South Carolina, said studies on 30 subjects (half of whom received 250 mg disulfiram daily and half of whom received placebo) showed disulfiram induced no significant abnormality, and precipitated no signs of depression in patients not ordinarily prone to depression.

There are many reports linking disulfiram to behavioral reactions such as depression, and there are surveys linking use of this drug to organic dysfunction, said Dr Keller. It is also true that many alcoholics suffer from depression.

But this does not mean it is disulfiram that induces the depression, he said.

"It is possible that disulfiram might induce minimal degrees of organic malfunction that cannot be detected in a population that is already demonstrating greater degrees of organic dysfunction.

"It is a rather unreasonable criterion for attributing an unwanted reaction to a drug . . . to subjects vulnerable to the unwanted reaction."

Consequently, Dr Keeler chose to test disulfiram's depression potential in subjects free from evidence of mania, schizophrenia, depression, organic brain dysfunction, and paranoid phenomena.

The subjects, who received either disulfiram or placebo over the course of one week, underwent a battery of tests measuring mood, coordination, organic dysfunction, reaction time, recent and remote memory, and verbal and performance capacity.

The results showed "absolutely no significant differences" between those who received the drug and those who received the placebo.

Furthermore, there was no evidence that drowsiness and fatigue were routine events of disulfiram treatment, said Dr Keller.

"It is our belief that if the initial dose were one gram of disulfiram, and this was reduced to 500 mg after three days, the results would be different," said Dr Keller.

"Much of the lore of disulfiram effect comes from the time when such a dose was utilized."

4,600 patients treated over 25 years, Antabuse is no poison, MD concludes

IT IS TIME to bury the myth that disulfiram (Antabuse) is a deadly poison, says Ruth Fox, a New York physician who has used the drug in about 4,600 patients over the past quarter century.

"I can attest to its absolute safety if the giving of it is carefully monitored in the first few weeks of therapy and the patient is cooperative."

This is particularly so since the dose has universally been reduced to 500 mg daily for five days and then 250 mg thereafter. After two or three years, many patients may stop taking it, says Dr Fox, although she recommends patients keep it on hand in case they are tempted to drink.

Ruth Fox

Dr Fox told the meeting: "I do not believe Antabuse works simply because it engenders a fear of drinking, but because it also cuts down the overwhelming conflict an alcoholic goes through when he is trying to control his alcohol intake.

"If he were not on Antabuse he might have to say no to the impulse to drink several hundred times a day when in the throes of a drinking period. When he is on Antabuse, there is no such conflict."

Dr Fox emphasizes that careful and specific instructions by physicians as to the patient's use of the drug are absolutely critical.

Warnings should be given patients about certain foods and drugs which contain alcohol — crepe sezettes, fruits swimming in brandy, and French salad dressing (which has wine vinegar).

Patients should also be aware of the risks of indiscriminate use of shave lotions and under arm applications (which contain alcohol) as well as the many cough syrups.

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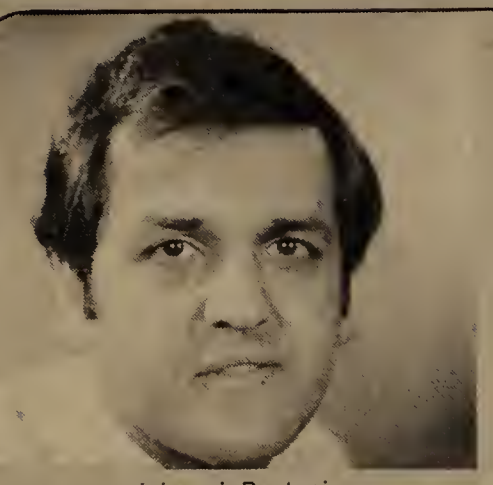
other drugs, potential hazards of benzodiazepines in the elderly and the ill."

Internists too came in for criticism as a consequence of the study. Dr Gottlieb suggested internists' "poor ability" to make the clinical diagnosis of depressive syndrome, together with their "alarming willingness to prescribe massive doses of tricyclic antidepressants suggest medical staff should not use antidepressant medication without expert assistance".

Internists also revealed a tendency to rely too heavily on pharmaceutical manufacturers' advertising material. In fact, 30% were so ill-informed they were likely to devise inappropriate pharmacological dose schedules, said Dr Gottlieb.

"If he (the psychiatrist) is to function as a teacher of medical students and non-psychiatric colleagues, he must be knowledgeable and capable of thinking on many levels: intrapsychic, interpersonal, psychological, and pharmacological.

"If he cannot," said Dr Gottlieb, "or if he chooses not to function in these ways, then he should abandon his claim to pre-eminence in psychopharmacology and his claim to working in medical education especially with the medically-ill."



Jehangir Bastani

Individual freedom

Court-committed alcoholics lag behind voluntary patients in treatment success

COURT COMMITMENT of the alcoholic to a course of involuntary treatment is coming under increasing scrutiny by advocates of civil liberties.

There are many who believe that only dangerousness to others justifies involuntary commitment, and that no amount of concern for an individual's welfare is sufficient reason to deprive him of his individual freedom.

These are arguments that cannot be taken lightly said Jehangir B. Bastani, acting chief of the psychiatric and neurology service of the Veterans Administration hospital in Lincoln, Nebraska. But neither can one negate the growing body of evidence that court commitment provides a positive form of intervention and treatment of alcoholics who might not otherwise come in for care, he added.

Dr Bastani reported on a three-year study of 75 alcoholics committed by the courts to the multidisciplinary Alcohol Treatment Unit of the VA hospital. These veterans were committed for their drinking problems by wives, family, or friends. Results of their treatment course were compared with those of voluntary, non-committed patients over the same time period.

It appears that both groups (committed and voluntary) did equally well in terms of improvement ratings during their three week in-patient stay. And though over a three-year follow up the voluntary patients did better in terms of maintaining sobriety, half of the court-committed patients did not return to drinking.

This is considerably less than the non-committed voluntary patients, says Dr Bastani, but 50% sobriety over a three-year period must be considered a "satisfactory outcome with alcoholics".

Of the voluntary patients followed up at three years, 27 were sober and nine drinking, compared to 20 patients sober and 19 drinking in the committed group. Drinking status of the others at follow up was not known.

In comparing the two groups it was noted that psychological profiles showed no consistent differences between the two groups. There were significant numbers within each group (about 30%) who had no real desire to achieve sobriety, and both had almost equal numbers of patients who showed a desire to abstain completely from alcohol as a result of their in-patient program.

One of the most consistent differences showing up during the treatment course was the much longer time spent by staff with the court-committed patients. Part of this was due to the involvement of the patient's family in the program as a means of working through the patient's resentment and anger at having been committed.

Some of the staff also sensed more individual responsibility in respect to this group — as if the community in general looked to them for successful rehabilitation of the court-committed patient.

Critics of court committment may postulate that the alcoholics in this group might well have sought treatment in future even without the courts, said Dr Bastani.

"However, the timely intervention of court committment, the real possibility of the patient, his family and environment undergoing irreversible damage by his continuing alcohol abuse was avoided."

arch thwarted under guise of 'subjects' rights'

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ated as a consequence of local political pressures.

He reported that a locally-constituted community research review committee felt that the investigation could draw defamatory conclusions regarding the competency of black mothers, and in order to effectively monitor the work, the committee asked to receive 10% of the research budget as overhead and demanded the right to censor reports emanating from the research.

The Committee had previously been given rights by NIAAA to review the validity of the program.

The project was moved to another community.

There is a recurring notion, said Dr Meyer, that research subjects must be protected from researchers by an adversary process (consent committee versus review committee versus review committee, patient advocates versus research physicians.)

The conflict is a salient one: do patients civil rights have primary over their rights to medical care?

Many self-help residential houses have increasingly restricted admission to patients who are court-referred because the drop-out rate of volunteers in these institutions is too high.

"In the absence of some system of control, the addict is not able to modify his own behavior," said Dr Meyer.

This concept is particularly important considering the high recidivism rate of heroin addicts discharged from prison.

We have . . . moved into an area where the ethics of human experimentation are increasingly being defined on the basis of imperatives that are more consistent with the principles, practices, and beliefs of civil liberties attorneys, said Dr Meyer.

"To some, the scenario is but one more repetition of the classic struggle between scientists and those who hold political power . . . as to whether science shall serve or be independent of political ideology."

nal drug index to monitor shifts in drug use

A NEW national index of psychoactive drug related deaths has been developed by a research team from the University of California at Irvine.

The index, keyed in to medical examiners' and coroners' offices in major urban centres, is expected to strengthen greatly existing means of monitoring future shifts in drug use in America.

Already, through its pilot testing in three cities, and its subsequent analyses of 2,000 drug deaths in nine urban centres, the index is being hailed as "the most extensive survey" of its kind ever done.

Jon F. Heiser, assistant adjunct professor, department of psychiatry and human behavior, told the meeting that the data base resulting from this index may allow a baseline against which to measure various treatment and intervention measures, and criminal justice deterrents.

The key to the system is a reporting form for drug-involved deaths which consists of about 135 questions concerning biographic and demographic variables; on-site toxicological and post-mortem investigations; treatment prior to death; psychological and psychiatric background; and suicide.

The cities used in this reporting network were Chicago, Cleveland, Dallas, Los Angeles, Miami, New York, Philadelphia, San Francisco, and Washington. The samples represented all or nearly all drug-involved deaths in 1973 in Dallas, Miami, San Francisco, and Washington, and certain proportions of reported cases in the other cities.

This is what some of the preliminary data showed:

- Of the 2,000 drug-related deaths, approximately two thirds were among male and were more often associated with narcotics, homicide, and other forms of violence. Female deaths were often associated with barbiturates and suicides;
- Among drug-related deaths, there were more Whites than Blacks, about one-third of the victims were unemployed, over half had been arrested at least once (a third convicted of felonies), many were heavy drinkers and smokers;
- Except for Cleveland, Dallas, and Miami, narcotics or barbiturates were involved in the majority of deaths;
- Narcotics related death victims were generally poorer than were users of other drugs, were more involved in street buys, and most often died accidentally from drug overdose;
- People whose deaths were barbiturate-related tended to be older, more often they obtained their drugs by legal prescriptions, and frequently they used these drugs to commit suicide;
- Barbiturate users were shown to have less involvement with heavy drinking than narcotic users and fewer arrest records; and,
- Depression, divorce, and marital separation were the most frequently noted stresses or problems. Suicide victims more often lived alone.

Dr Heiser emphasized the importance of continuing this monitoring effort and correlating the findings to other data concerning drug-involved deaths. The UCI team is currently collecting data on an additional 1,000 cases of drug-involved deaths in the same nine cities.

It is also conducting proficiency testing of toxicological laboratories involved in the network. To date it has found considerable variation in the reliability of these labs due to different procedures used in different cities.

The research teams index efforts were supported by NIDA and SAODAP.

Alcoholism and Drug Abuse 1976:

Mary Hager reports from San Francisco

Cross-cultural studies highlight conference

"ENLIGHTENMENT IS creeping in" to the drug abuse and alcoholism treatment fields, David Smith said here.

Ten years ago at the first Alcoholism and Drug Abuse Conference sponsored by the Haight Ashbury Free Medical Clinic, presentations were made about the cross-cultural uses of drugs "but we were criticized for encouraging drug use," Dr Smith recalled.

A full morning session at this year's conference was devoted to cross-cultural comparisons and some historical perspective on alcoholism and drug use — and the reactions were totally different.

"It is really encouraging that this type of presentation is now well received," Dr Smith observed. He is director of the Haight Ashbury Clinic and conference chairman.

One participant, Marlene Dobkin de Rios of the medical anthropology department at the University of California, San Francisco, noted that "abuse is not a factor in the traditional societies of the world".

The biological, psychological, social-interactional and cultural variables within a society interact with the pharmacological effects of given drugs. There is a great deal of "stereotypical patterning of drug experience." Visionary experiences, for instance, are often culturally programmed and part of the socialization process, Ms Dobkin de Rios explained.

As in other societies, there is a certain degree of drug ritualization in American society, she continued, citing the cocktail party, the smoking ritual and rock concerts as examples. Such ritualistic use is considered "destructive by much of American society," an attitude which "has to do with prohibitive patterns without regards to harmful effects".

Anthropological and cross-cultural analyses suggest that certain aspects of society define what is use and what is abuse, she noted. For instance, in the pre-Spanish new world, the use of alcohol once led to a reprimand, and after that the offender was killed, a situation which changed when the Spaniards arrived.

She said she would like to see drug abuse defined as when the substance seriously interferes with the health and functioning of an individual.

She also suggested the "generational components" be considered. The psychoactive drugs of preference in one group might contrast with the hallucinogens of another, she said.

John Kramer of the department of pharmacology at the University of California, Irvine, debunked the myth that heroin was introduced as a treatment for morphine.

Heroin, Dr Kramer said, was introduced at the end of the 19th century as a substitute for codeine in cough supressants, since in much smaller doses it was much more effective than codeine. It did not have the side effects of codeine and seemed ideal until one physician noted that some patients tended to become addicted and others needed increasingly higher doses.

David Smith

The idea that heroin was introduced as a treatment for morphine and was widely used was probably part of the efforts in 1910 to get the National Drug Control Act passed, Dr Kramer suggested.

"Neither Congress nor the public was very concerned with addiction at that time and the data was distorted to sell the idea. People who were victims became 'drug fiends' " and the demonization idea was created, he noted.

Such thinking, Dr Kramer added, "created our attitudes and many of our problems." It also pinpoints the difficulties society has coming to terms with drug use and the risks.

"We have got to look at other societies and other times to understand the roles and risks and how to handle drug use," he said.

Barbara Myerhoff, associate professor of anthropology at the University of Southern California, described the "peyote hunt" experience of Mexico's Huichol Indians. Dr Myerhoff defined as common elements of their highly ritualized drug use, a sense of unity, peacefulness, eucharistic brotherly love, a transcendence of space and time, and "upside-down, backwards quality of life" and a loosening of social cognitive categories, often leading to creative expression.

To the Indians, peyote is a drug of non-abuse, she said, and all members of the tribe have used it. Peyote, is thoroughly embedded in the tribal customs.

Drug abuse field lacks creativity

CLEAN URINE should not be the sole criterion for success in the treatment of drug addiction, in the opinion of a California physician.

Josette Escamilla-Mondanaro, medical director of the Adolescent and Young Adult Alcohol Program and director of the Pregnant Addict Program at Marin Open House, suggested that "a better indication is that the individual has learned to do something else".

Methadone, she said, is "not the answer," since it "perpetuates the bad parenting" by implying that addicts are irresponsible and failures.

In addition, methadone is a highly anesthetizing drug. "If a patient is not feeling psychic pain, you can't do therapy".

"Methadone, is counter productive. It won't and doesn't work."

She observed it is hard to go against methadone, because that is what gets the funding, but she challenged that "all of a sudden the drug abuse field has lost creativity. We need to go back where the spirit was when we got into the field".

"Programs haven't produced success and many are moving into other fields leaving behind those they started to serve," she said. "I think we've lost our soul."

The drug is not what makes the difference, "it's something that comes before the bad choice". She noted that some "battered individuals" turn to drug abuse, some are suicidal, some depressed and some workaholics.

They can be helped, but they need a warm environment and a one-to-one relationship "with a closed door. They need trust and respect".

Alcoholics need benefits

Expanded coverage among NIAAA goals: Noble

"TO BRING treatment into the mainstream of the health system and to provide vastly expanded coverage," are primary goals of the National Institute of Alcoholism and Alcohol Abuse, according to Director Ernest P. Noble.

Dr Noble told the meeting that insurance carriers and third-party payers must be convinced that alcoholics need both resources and treatment, as he spelled out the priorities of the NIAAA.

It is important for alcoholism to be covered as a primary diagnosis, and for coverage to be provided for treatment away from a general hospital setting, he stated. Currently, Dr Noble added, benefits are only available to alcoholics who are already in a "sorry state".

Ernest Noble

He also emphasized a need for greater training in alcoholism for all health professionals. Another goal is to establish courses in alcoholism in all medical and allied health schools and to ensure that physicians already in practice also have access to such courses.

He recalled his own lack of exposure to alcoholism during his training and the lack of compassion shown for alcoholic patients on the ward.

"Alcoholics were an object of scorn," he said. "The attitude was that they would either die, or that they would get symptomatic relief, be discharged, return to drinking and die later.

"This attitude persists," Dr Noble continued. "The stigma and bias need to be replaced by understanding.

"Alcoholism," is a behavioral, biological and social problem. The answers will not be found in a test tube."

He noted that alcohol has been embedded in man's culture for generations and that alcohol does have the properties of a drug, in addition to the psychological and social aspects.

The health problems are severe, but social activities involved with alcoholism "are heavily imbedded in the culture." Further, alcohol is legal, he said.

"It is a complex issue. Society shrugs the warnings. Statistics show accelerated use, particularly among women, the disadvantaged and youth," he said. "It's disheartening. I suspect the statistics will continue to mount."

The answers "will need the best minds we can find," Dr Noble stated. "We need more than a partial solution. We need more than a Bandaid. We must spend more time investigating areas outside of the laboratory".

In another presentation, Stuart Nightingale, assistant director of the National Institute of Drug Abuse, noted that research is a "high priority area" for NIDA. The Institute has a commitment to epidemiology, and to efforts to make information as widely available as possible, Dr Nightingale said.

Provision of technical assistance to single state agencies and to communities, as well as direct delivery of service to those who need it, are other priorities of NIDA, he said.

Dr Nightingale cited international activities which are "not a very visible activity," but essential to the overall control of drug abuse. Such activity consists mainly of technical assistance to countries that have a significant drug abuse or drug traffic problem, he added.

NIDA has now achieved "bureaucratic maturity" which will enable the institute to carry out functions more effectively. NIDA has become a leader in setting standards and in reviewing criteria involving drugs and drug abuse for other agencies, Dr Nightingale noted.

Loran Archer, director of the Office of Alcoholism in California, said that California receives back only 1% of the federal alcohol taxes paid by the state in terms of programs for alcoholism.

"This is a poor form of pre-paid health insurance," he said. Alcohol taxes are an easy source of tax revenue, but the revenues are rarely used for treatment and rehabilitation, he charged.

"I think it is important that the alcohol taxes be raised again, but the money should be used for the treatment and rehabilitation of alcoholics. I feel the federal government has great responsibility in the provision of resources," Mr Archer said.

Prevention is a major concern of the State Office of Narcotics and Drug Abuse, Director Stuart Snyder told the audience. Prevention is tremendously important, he noted, because treatment programs offer only "finite success".

He added that "we have to stop the increase in all kinds of drug use".

He said it is essential to bring all kinds of drug abuse programs, including alcoholism together. Instead of competing for money, "I think the programs should fight together."

COLLISION COURSE

AWARD WINNER!
"Best of Audiovisual Media Festival"
– BIOCOMMUNICATIONS'76

Content and Purpose

"Collision Course" is a dramatic essay which explores the potentially tragic consequences of mixing even moderate amounts of alcohol with the complex task of driving.

It is designed to impress upon the viewer that one is at risk even when generally socially-acceptable drinking behavior is practised.

The viewer is introduced to a young middle-class couple and their parents. The film follows the young couple's activities throughout the evening; taking in a movie and having a few beers with friends. At the same time, their parents are discussing some known facts relating to problems contributing to the carnage on the roads. Also introduced is a blue collar worker who, after a tiring day on the job and a couple of after-work drinks, takes to the highway.

The film dramatically analyzes the behavior of the indviduals involved and their subsequent actions.

As the audience is geared to suspect from the first, the young couple and the blue collar worker eventually meet . . . in the middle of the night on a lonely road.

Audience and Use

Collision Course is an action film which is ideal for use with a variety of audiences (e.g. driver education programs, driver training courses, home and school associations, student groups, community action groups). Community workers in the alcohol and drug dependency field will find this film a valuable teaching aid in the exploration of legal, social and behavioral aspects of drinking-driving issues.

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Addiction Research Foundation,
% Marketing Services
33 Russell Street,
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This film will not be available until May 7, 1976

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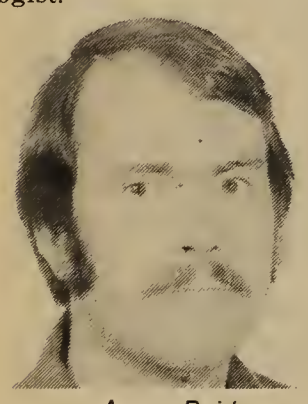
16mm, color film , 17 minutes

Canada's alcohol programs are 'stagnating'

By Manfred Jager

WINNIPEG—There is growing indication that alcoholism treatment and rehabilitation programs in Canada are stagnating and less effective than they could be because of a reluctance to try new ways, says a University of Manitoba sociologist.



Angus Reid

Angus Reid, assistant professor of sociology in the university's department of social and preventive medicine, said in an interview part of this reluctance in the alcoholism treatment field could have to do with funding difficulties.

Dr Reid is conducting a $127,000 nation-wide study of alcoholism treatment and rehabilitation programs. The project involves himself and one research assistant, as well as 14 so-called contractors, who will interview therapists and clients of between 500 and 700 alcoholism treatment programs from coast to coast this year.

The team hopes to have most of the research data by next autumn. A report on findings and interpretation is not expected until a year from now.

The research is supported by the Non-Medical Use of Drugs Directorate in the federal health and welfare department.

Preliminary indications suggest "that research doesn't have the kind of effect one might think it has on the treatment of the alcoholic," said Dr Reid.

"It doesn't seem to be a question of one going out, doing research, and then translating the results into (treatment) program policy."

In some cases this means research was a waste of money, Dr Reid said.

"We often spend money on research which tries to legitimate decisions people already intended to make before the research got underway."

Dr Reid added: "At the heart of this study is the wish to find out the extent to which alcoholism treatment and rehabilitation programs across the country are able to be creative and innovative.

"I have yet to see a research report on any phase of treatment which is optimistic about our ability to treat successfully.

"Most studies will say, in effect, yes, perhaps a number of people can go through this or that specific program and do fine, but on the whole people may as well just stay home and not bother."

In Dr Reid's opinion, this indicates "we have a pressing national health problem—alcoholism—and are not able to be as effective in dealing with it as we might be.

"So, the question I ask is how can we develop organizations and programs which will be very sensitive to innovation—programs which will be willing to experiment and innovate."

Dr Reid conducted a similar, limited study on the effectiveness of alcoholism treatment here in Manitoba last year.

"One thing that study showed was that there are built-in constraints against any kind of innovation and experimentation in the field in this province.

"The one pattern of innovation that seemed to be employed was actually to start new agencies—and they are always started up on very precarious funding. You never really have a chance to try out new models of treatment in any significant way when you go this route."

A result of this has been that "the field is becoming increasingly resistant to innovation, and the uncertainty of funding is one reason for this," said Dr Reid.

"Just look at the funding in this field—it's ridiculous. There seem to have been more than a hundred Local Initiative Program projects around the country regarding alcoholism a few years ago. Now you can't find any of them."

More Letters...

(continued from page 4)

In the very editorial which Dr Rudin uses as the launching pad for his response, he seems to have blacked out such key phrases as: "*Despite some pretty sound evidence that the drug can't be good for anyone's health* (just as tobacco and alcohol can't) *and that it might in fact be harmful*, decriminalization is taking place".

He then "defies" **The Journal** to go back through its past issues to "fine one — just one" article which gives a rather unfavorable view of marijuana, and suggests that this can't be done.

Decriminilization must not imply endorsement . . . . Pot harmful to heart disease patients . . . Scientist sees long term pot risks . . . To legalize pot would be a mistake . . . are headlines that have appeared in **The Journal** far more recently than six months, and that is just for starters.

The Journal has never urged legalization of this drug, it has never suggested this is a benign chemical. It has sought, and will continue to seek, a rational discussion of the real issues that surround use of this drug — one of the most critical issues being the emotionalism of extremists to whom objectivity itself is anathema — because objectivity allows the "other" guy to speak his piece.

To reiterate from our May, 1976 editorial, one that should not have escaped Dr Rudin's scrutiny: "Decriminalization is occuring in many places. And in light of that fact (we) urge society to make adequate preparation to keep the *potentially harmful health and social effects of marijuana use* to a minimum".

We also suggest Dr Rudin purchase a copy of **The Journal**'s anthology of cannabis articles published between 1972 and 1975. This is the one entitled: *The other side speaks out . . . cannabis a highly dangerous drug.*

As for Dr Rudin's philosophical non-sequitor: to be pro marijuana is to be anti-establishment is to be anti-American . . . WHEW! For a staff that spends so much time in the US reporting on activities in the drug field to be called xenophobic is . . . well . . . xenophobic.

The fact that Dr Smart is only able to hint at possible reasons for recovery in the two groups suggests that improvement upon our current efforts at rehabilitating problem drinkers and drug addicts — regardless of whether or not this involves treatment as Dr Smart somewhat ambiguously defines the term — will be very much a function of the extent to which refinement in identifying the specific factors associated with recovery continues as a research priority in the chemical dependence field.

David Blackwell
Director,
Pilot Projects
Addiction Research Foundation

Self-care

Dear Sir,

At a time of increasing public concern with the costs of health care services, Reginald Smart is to be congratulated on his statement questioning our widely held assumptions about the effectiveness of treatment services for problem drinkers and drug addicts (**The Journal**, June).

Please permit me to add a couple of additional comments.

It is quite true, based on the evidence of the research literature to date, that in general "spontaneous recovery" appears to account for almost as much improvement among problem drinkers as involvement in formal type treatment. However, Dr Smart's other point that changes are observed to take place among a percentage of individuals in both groups is also highly significant and not to be overlooked.

Restrict use

Sir:

Once again **The Journal** has brought to its readers detailed information regarding the alcohol problem in many parts of the world.

The recent report from the findings of Terry Jones MPP in Ontario contains many worthwhile suggestions and recommendations; Roy McMurtry, Attorney General for Ontario offers wise counsel in different fields of restriction; Marc Lalonde, Federal Health Minister recommends revised regulations on advertising in that such never presents "the truth" as to what "alcohol is and does".

Millions of dollars have been spent on establishing various commissions to study the alcohol problem, and especially the teenage drinking problem which has been more prevalent since the lowering of the legal drinking age.

Nothing is ever done to eliminate or delete the one and only cause of the problem *alcohol*. While the so-called epidemic of alcoholism continues to increase, and teenagers become alcoholics at an earlier age than ever before, our controlling agencies continue to open more outlets, issue more licences, and remove legislation that is in any way restrictive, thus encouraging more people to drink, moderately of course.

The whole program seems to be inconsistent, worthless, and ineffective. It provides no solution to the problem. I commend Harry W. Beardsley for his comments on "dealcoholization" in **The Journal** (May). Farmers are restricted as to the amount of milk they can produce. Can the alcohol industry not be restricted as to their amount of production?

Janet L. Armstrong, Editor,
Ontario WCTU News Bulletin
Spencerville, Ontario

Around the World

Bootleg liquor

Three thousand people have died in India each year since 1950 from drinking lethal bootleg liquor. According to the *Illustrated Weekly of India*, thousands of others have been blinded or physically handicapped by the corrosive ingredients in the home-made hooch.

Leaders stop drinking

President Gaafar al-Nimeiry of Sudan has warned his ministers and legislators to give up alcoholic drinks or resign. In an open letter, the President said he "will find no excuse in the ill-behavior of my aides". His letter, published in local newspapers, gave the leaders one week's grace to declare their intentions.

Teenage alcoholics

Sweden has banned the country's most popular beer because it was causing teenage alcoholism. Parliament voted to abolish the medium-strength 'Two B' beer which contains 3.6% alcohol, from July next year. Only a weaker brew containing 2.8% alcohol will be available after that time in grocery stores. A stronger beer with 4.5% alcohol will still be available in state-monopoly shops which strictly enforce a minimum age of 20 for customers.

None for the road

To make the public more aware of the alternatives to alcoholic drinks, the New South Wales Temperance Alliance of Australia staged a 'None for the Road' campaign recently. Free samples of non-alcoholic drinks were handed out to the public on separate occassions, including a Juice Julep, Cider Rickey, and Tall Clove Purple.

Scots vodka

Scotch is enjoyed by half of Scotland's adults but vodka, white rum, and sherry are nevertheless gaining popularity. A recent survey showed that after whiskey the popularity of drinks was sherry, vodka, brandy, white rum, gin and dark rum. The under-25's like vodka best.

Czech drinkers

Only half of the 15-year-olds in Czechoslovakia drink no alcohol. By the time they are 18, only 17% do not drink, according to a Czechoslovak newspaper.

Cairo bill

The Egyptian People's Assembly has adopted a bill forbidding Egyptians to drink an alcoholic beverage in public. Supporters said the bill would curb violence and make society conform to Islam the state religion. The bill also bars sales of liquor except in certain shops, and advertisements of alcoholic drinks in public places.

Alcoholism in New Zealand known as 'Catholic disease'

AUCKLAND, NZ — Roman Catholics in New Zealand have an incidence of alcoholism twice as high as that of the rest of the community, according to recently published figures.

Catholics, both nominal and practising, comprise 15.8% of the total population. But they apparently make at least 30% of the country's estimated 100,000 alcoholics.

In Auckland, Henry Whittle, who is in charge of the Carrington Hospital intensive therapy unit for alcoholics, speaks from 10 years' experience in describing alcoholism as "the Catholic disease".

A recent spot-check on 200 consecutive admissions to his unit revealed that 31% were Catholics.

In Wellington, the superintendent of the Salvation Army's treatment program, Major Noel C. Manson, reports a 37% ratio of Catholics among total new admissions in 1975.

Dr Whittle believes the main cause of the high incidence of Catholic alcoholism is spiritual.

"Catholic alcoholics," he maintains, "are hounded by their concept of a harsh, unforgiving God. With their burden of guilt — some real, some neurotic — they are completely devoid of hope. Catholic alcoholics have absolutely no concept of the Christ who loves with an infinite love even while we are sinners."

The medical superintendent of Carrington Hospital, Fraser McDonald, who is also widely experienced in treating alcoholism, believes the Irish cultural tradition among New Zealand Catholics is a major culprit, giving rise to a distorted idea of hospitality and a false concept of masculinity.

He says Catholics have ambivalent feelings about alcohol. On the one hand, they tell their children that drunkenness is a terrible sin; but on the other-hand Irish Catholic tradition demands that ordinary hospitality be shot through with heavy drinking behavior.

"Putting alcohol into people like this is a very sure way of manufacturing alcoholics," he says.

Dr. Whittle and Dr McDonald — themselves both Catholics — say the church in New Zealand is not facing up to the problem of alcoholism among its members, either by edueating itself or by providing adequate facilities for treatment and rehabilitation.

UK barmen are under attack

LONDON — Bartenders who are unwilling to tackle teenagers on legal or erowd control grounds are in part responsible for the alarming rise in violent crimes associated with alcohol and committed by young people, says Anthony Armstrong, Chief Constable of Bedfordshire county, north of London.

He made his attack on barmen in presenting a report on Alcohol and Crime published by the Christian Economic and Social Research Foundation. As part of the study, Mr Armstrong arranged for 1,220 court cases in Bedfordshire to be monitored by researchers.

The report said there were nearly 100,000 proven cases of drunkenness in England and Wales in 1975. In addition, police initiated more than 66,000 proceedings for drinking and driving offences.

"Probably two-thirds of a million crimes and offences might not have occurred if alcohol had not been consumed at a critieal time, and it is possible that the number touched upon a million," it adds.

Mr Armstrong, who said he is a social drinker, declared: "A great proportion of today's violent crimes are committed by juveniles after drinking.

"The weakness of some barmen, ill-equipped to deal with habitual drunkards and unable or unwilling to refuse drinks to juveniles, must contribute to some extent to alcohol-associated crimes."

Many young lives had been spoiled and a number of teenage boys killed after fights at discotheques and dance halls. Almost always there was incontrovertible evidence of excessive drinking, Mr Armstrong claimed.

In many areas, teenage toughs are so rowdy and rough that they in fact dominate a number of pubs and have driven out older customers, who prefer to drink in their own homes instead of risking an unprovoked attack.

Mr Armstrong said he thought the ideal British barman should be "a physically imposing man, a man who is fairly young who has a knowledge of the licensing laws and who is a responsible person".

The Chief Constable said he was in favor of an examination for barmen coupled with a training course similar to those now carried out by the large breweries before putting people in charge of pubs in their chains.

Mr Armstrong declared that the present law, which permits teenagers to drink at age 18 is perfectly adequate. However, this law must be enforced and he would be against any drive to have the legal age for drinking lowered.

If barmen took their job seriously, and exercised their strength and knowledge of the laws, then many pubs could lure back the lost older customers.

Researchers said in their report that nearly half the men charged with offences concerning theft had drunk before they carried out the crimes. More than 50% of those charged with dangerous or offensive behavior had had something to drink beforehand.

Health survey shows

Israeli MD's quit smoking

JERUSALEM—Thirty per cent of the doctors in this city have stopped smoking — as compared with only 13% of the general population, according to a survey just completed by the Ministry of Health.

The survey was among all the city's doctors, and 70% (or 600 doctors) answered the questionnaire.

Of those answering, 45% said they had never smoked; 30% said they had stopped; 18% smoked cigarettes and another 7% smoked pipes or cigars.

Surprisingly, of the 18% cigarette smokers, 27% smoked five or fewer cigarettes a day and 21% smoked between five and ten eigarettes a day.

Young addicts grouped together in British treatment program

LONDON — Britain's first specialized alcoholism treatment program for young people within the National Health Service — established in the city of Glasgow — has produced some promising results.

Jay Fischer, Charing Cross Clinic for Drug and Alcohol Problems, Glasgow, and Brian Coyle of the Douglas Inch Clinic for Forensic Psychiatry, Glasgow, said the Young Persons Program — known as the YPP and restricted to patients under 30 — had produced a five-fold improvement in respect of "continued treatment contact" for that age group.

The workers said the usual practice in Britain is for young patients to be included in treatment where the predominant age range is 35-50. Specialized treatment for the under 30s within the NHS was 'non existent', they said.

Yet the practice of interspersing younger with older drinkers ignored the possibility they might have different or more severe emotional problems, and that these could best be dealt with by separate treatment. The practice might also undermine a basic feature of specialized treatment — the fostering of group cohesiveness.

A closed group of eight patients formed the first YPP. Patients were considered unsuitable for treatment if they demonstrated psychotisism, low level of motivation, self-injecting drug abuse, or barbiturate use.

Meetings lasting 75 minutes were held on Tuesdays and Saturdays (it was thought important to include a weekend meeting because that is when drinking is heaviest in Glasgow). Within the group, patients were encouraged to express and explore feelings about themselves and other group members.

"Considerable emphasis is given to exploring present problems, as opposed to past history," the authors said. "Such an approach offers maximum possibility for modifying present maladaptive behavior (Mintz 1971). This is not to minimize the importance of past experience — but rather it is our clinical judgment that undue emphasis on the past is often a means of avoiding present interpersonal or intra-psychic difficulties."

Individual treatment goals were set at intake interview. Early alcohol abusers might be urged to return to moderate drinking while advanced alcohol abusers would be given abstinence as an objective.

Dr Fischer and Mr Coyle said the original intention to admit new patients after intake interview and as space became available, was dropped because "premature terminations" (some patients failed to attend more than one session) proved discouraging to other group members.

Instead, the group suggested that following intake interview, potential new patients should attend a basic discussion group called the "survival group".

Patients are now required to attend the Survival Group for three weeks before admittance to the YPP itself.

Comparison of 16 YPP patients with a group of 72 patients aged over 30, showed that 37.5% of the first group completed 15 sessions whereas only 21.0% of the older group did.

The success of the YPP continuation rate was five times as great as was achieved with that age group before the YPP was set up.

Dr Fischer and Mr Coyle consider the results challenge the notion, suggested in the literature, that younger patients have a poorer prognosis with respect to continued treatment contact than do older patients.

They also suggest specialized treatment services for young problem drinkers should be further explored. Cohesiveness and continued treatment contact are related, they stressed, to successful treatment.

New Books

by RON HALL

Evaluation of Dependence Liability and Dependence Potential of Drugs

. . . Report of a World Health Organization Scientific Group

This report reviews the work of the WHO on the evaluation of dependence liability and potential of drugs, and considers the pre-clinical and clinical methods of assessing their physical dependence. Methods of detecting the existence of drug problems in society are included, and research and methodological issues concerning the evaluation of dependence liability and potential of various categories of psychoactive drugs are discussed. The report concludes with several recommendations for research.

(World Health Organization Technical Report Series, No. 577. Information Canada, 171 Slater St., Ottawa, Ont. 1975. 50p.)

Predicting Adolescent Drug Abuse: A review of Issues, Methods and Correlates

. . . edited by Dan J. Lettieri

This book contains a collection of recent work on aspects of the prediction of drug-abusing behavior with particular reference to youth. The topics discussed include; conceptual issues, nosologicial and clinical approaches, methodological issues; intrapersonal, behavioral and interpersonal factors, and developmental studies.

(National Institute on Drug Abuse, US Government Printing Office, Washington, DC, 20402. 1975. 371p $4.90)

Other Books

The Persistent Poppy: A Computer-Aided Search for Heroin Policy—Levin, Gilbert, Roberts, Edward B., and Hirsch, Gary B. Ballinger Publishing Co., Cambridge, 1975: Heroin addiction, narcotic control, system analysis. 232p.

Management of Adolescent Drug Misuse: Clinical, Psychological, and Legal Perspectives—Gamage, James R. (ed). STASH Press, Beloit, 1973: "Proceedings of the second annual symposium of the Student Association for the Study of Hallucinogens." 139p.

Drug Effects on the Fetus—Techmann-Duplessis, H. ADIS Press, Sydney, 1975. "A Survey of the mechanisms and effects of drugs on embryogenenisis and fetogenesis." 267p.

The Economics of Methadone Maintenance—Hannan, Timothy H. D. C. Heath and Co., Toronto, 1975. Addict behavior, benefit of methadone, treatment, program and problems of evaluation, cost-benefit. 165p.

Marijuana and Health Hazard—Tinklenberg, J. R. (ed). Academic Press, Inc., New York, 1975. 178p.

Drugs in Combination with other Therapies—Greenblatt, M. (ed). Grune and Stratton, Inc., New York, 1975. 202p.

Coming Events

JULY

Potsdam Institute on Alcohol Problems — July 12-23, 1976, Potsdam, New York. Information: Dr Louis LaGrand, Institute Director, State University College, Maxcy Hall, Potsdam, New York.

Alcoholism and Other Drug Dependencies 1976 — July 29-30, 1976 — Seattle, Washington. Information: The Alcoholism and Drug Abuse Institute, University of Washington, Seattle, 98195.

AUGUST

The Problems and Promise of University Based Employee Assistance Programs, Aug. 1-3, 1976, Columbia, Missouri. Information: Employee Assistance Program, 215 Columbia Professional Building, Columbia, Miss., 65201.

11th International Conference on Medical and Biological Engineering — Aug. 2-6, 1976, Ottawa, Ont. Information: Conference Office, National Research Council, Ottawa, Ont., K1A 0R6.

International Doctors in Alcoholics Anonymous — Aug. 5-8, 1976, Los Angeles, Cal. Information: Lewis K. Reed MD, Secretary, IDAA, 1950 Volney Rd., Youngstown, Ohio, 44511.

17th Institute on Addiction Studies — Aug. 15-20, 1976, McMaster University, Hamilton, Ont. Information: David E. Reeve, 15 Gervais Dr., Suite 603, Don Mills, Ont.

Symposium on Drug Dependence, Alcoholism and Criminality — Aug. 16-20, 1976, Sao Paulo, Brazil. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

Second World Congress of the International Commission for Prevention of Alcoholism — Aug. 22-27, 1976, Acapulco, Mex. Information: ICFPA, 6830 Laurel St., NW, Washington, DC, 20012.

9th International Conference on Health Education — Aug. 29-Sept. 2, 1976, Ottawa, Ont. Information: Canada's Organizing Committee, 9th International Conference on Health Education, Canadian Health Education Specialists Society, PO Box 2305, Station D, Ottawa, Ont, K1P 5K0.

SEPTEMBER

2nd International Symposium on Victimology — Sept. 5-11, 1976, Boston, Mass. Information: 156 Federal St., Boston, Mass.

27th Annual Meeting of Alcohol and Drug Problems Association of North America — Sept. 12-16, 1976, New Orleans, Louis. Information: ADPA, 1101 15th St., NW, Washington, DC, 20005.

Alcoholism: Advances in Medical and Psychiatric Understanding — Sept. 25-29, 1976, London, Eng. Information: Alcohol Education Centre Limited, The Maudsley Hospital, 99, Denmark Hill, London, SE5 8AZ.

First World Conference on Therapeutic Communities — Sept. 27-Oct. 1, 1976, Katrineholm, Sweden. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

OCTOBER

Familie und Suchterkrankung — Oct. 4-7, 1976, Dusseldorf, Germany. Information: DHS, D-47 Hamm, Postfach 109, German Federal Republic.

2nd International Symposium on Alcohol and Aldehyde Metabolism — Oct. 16-17, 1976, Philadelphia, Pa. Information: Dr R. G. Thurman, 409 Anatomy-Chemistry Building, University of Pennsylvania, Philadelphia, Pa, 19174.

Fourth Congress of the Comite National de Defense Contre L'alcoolisme — Oct. 14-16, 1976, Strasbourg, France. Information. ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct. 20-23, 1976, San Diego, Cal. Information: Pamela Maroe, ALMACA, Suite 410, Reston International Center, 11800 Sunrise Valley Dr., Reston, Va, 22091.

20th Annual Conference of the American Association for Automotive Medicine — Oct. 31-Nov. 3, 1976, Atlanta, Georgia. Information: James Fell, National Highway Traffic Safety Administration, N43-32, 400-7th St., SW, Washington, DC, 20590.

NOVEMBER

International Conference on Alcoholism and Drug Abuse — Nov. 13-18, 1976, Baghdad, Iraq. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

1st National Conference on Issues in Juvenile Justice and Child Development — Nov. 14-17, 1976, McAfee, New Jersey. Information: Ronald Krate, Department of Psychology, William Paterson College, Wayne, NJ, 07470.

1977

6th International Conference of the World Union of Organizations for the Safeguard of Youth — May 31-June 4, 1977, Geneva, Switzerland. Information: World Union of Organizations for the Safeguard of Youth, 28, Place Saint-Georges, 75442 Paris, Cedex.

In order to provide our readers with adequate notice of forthcoming events, please send announcements as early as possible to: The Journal, 33 Russell St., Toronto, Ont., M5S 2S1.

Positions Available

Human experimentation - a question of ethics

By Joy-Ann Cohen

A FEELING among scientists that no experimenter can decide for himself if what he does is ethical, is prompting ethical review committees on human experimentation to spring up in North America and Britain.

"Unless the profession polices itself, it will be policed externally," says Frederick Glaser, head of psychiatry at Ontario's Addiction Research Foundation.

"If we could use the ethical review to avoid this, we will have room to negotiate. Ethical reviews will preserve the right of scientists to investigate."

For the moment, however, there is no way, other than by hearsay or personal knowledge, that one ethics committee knows what another does.

"There should be some community of people who are involved in ethical deliberations to do a systematic review," Dr Glaser says.

The only option to ethical review committees, says Dr Glaser, is to have the whole burden of legal responsibility fall on the individual experimenter. Most experimenters, he adds, are not willing to risk this.

But, when scientists are exempt from ethical responsibilities "the results are occasionally grotesque," Dr Glaser says. He mentions human experimentation in Nazi Germany and the dropping of the atom bomb . . . "although more frequently the results are trivial".

The major aim of an ethical review committee on human experimentation is to minimize risks to subjects while still allowing experiments that will benefit society.

Yet, even with a committee's approval, subjects may still encounter some risks to their safety.

Wilfred H. Boothroyd, acting director of the ARF and chairman of that organization's first such committee, says: "If the value of the findings is great to a large number of people and the risks are small to a small number of people, then the risks are worth taking."

A proposal for an experiment on controlled drinking that went before the ARF's ethics committee on human experimentation serves as an illustration.

The aim of the study was to teach married, male alcoholics to drink in moderation. Both experimental and control groups were to receive counselling on improving their marrigaes. But the experimental group was also going to drink on the ARF premises. Thus, the experimenter could watch subjects' drinking behavior and help them learn to drink in moderation.

The experimenter, a psychologist named Wayne Thompson, who hoped drinking in this "moderation climate" would be a model for later drinking outside the institution, says the main concern of the ethics committee was: "Do we know enough to risk clients drinking on an out-patient basis"?

The committee was concerned that subjects might drive or get into a fight after drinking at the ARF. Those who continued drinking over a period of time might develop cirrhosis of the liver. If such activities led to a court trial, the institution could be legally responsible.

"It is not good to submit patients to the most harmless research if it is not scientifically sound . . . . There is too much research already that is repetitious, not worth doing, and not well-planned," says Hector Orrego of the ARF department of medicine where a scientific review precedes review by the ethics committee.

Fred Glaser

Who may ethically be used in an experiment is also a question that always arises. If an alcoholic or drug addict is offered his drug of abuse in an experiment, could this have bad effects on him or her?

In, for example, a controlled drinking study proposal, the question is: Will giving alcohol to an alcoholic *add* to the problem?

Subjects might also think the experimenter is sanctioning their drinking behavior.

Dr Glaser says a problem exists regarding "the extent to which you are coercing the subject by offering the drug of abuse.

"This is not so much a problem with volunteers, whom you may not be coercing any more than society in general. But, in a prison population, you might be coercing subjects if you are the only source for that drug, or if the prisoner can get his sentence reduced by taking it."

Subjects for an experiment must also be able to make an informed decision on whether they want to be in it, and sign a form agreeing to participate. This means the scientists must give subjects a detailed explanation of exactly what is going to be done and of the risks.

Howard Cappell, head of psychology at the ARF, says that for himself the biggest contribution the ARF ethics committee has made has been to advise on what subjects should be told about experiments.

Recently, certain groups of people have been used less in experiments, because both courts and scientists feel they are incapable of giving informed consent. These include people with a different language or culture from the experimenters, or people who are mentally ill, deaf, or illiterate.

"The issue of informed consent for methadone is fascinating," Dr Glaser says. Some people coming into the Clinical Institute under the influence of certain types of drugs are offered methadone as treatment, and as part of an experiment.

They sign a consent form when they first receive methadone, but there is a possibility that some may not understand what they are signing. So they are asked to sign it again after three weeks, and again after six weeks.

Preserving the confidentiality of a subject can protect his safety. Sometimes this means deciding whether it is ethical for the experimenter to look at past records or have an interview with the subject that he has not requested himself.

Dr Glaser says: "The central issue is whether it is ethically justifiable to do an experiment using human subjects if there is no foreseeable value to those individuals or people in the future . . . . I think the price for using human subjects is to show an experiment might be of benefit to other people."

Dr Cappell says: "An experiment is not justified on the basis that it is providing treatment for the people who are taking part. The hope is that by discovering what is true, someone will benefit in the future."

On weighing benefits and risks, Dr Cappell says: "Before I decided whether an experiment had too many risks to undertake, I would like to know if what we're doing now is better."

He adds: "Most people who control money supplies for experiments are politicians, and they want to know what the results will be tomorrow."

In Dr Cappell's opinion, this encourages scientists "to exaggerate the immediate benefits of their research".

The ethics review committee on human experimentation at the ARF was set up in 1971.

Its six core groups members are a chairman and representative of the professional advisory board from the ARF; a research administrator, a criminologist, and the director of student health services from the University of Toronto, and a lawyer.

The head of psychiatry at the foundation also sits on the committee when it is deliberating Clinical Institute cases.

In addition, two people selected for their knowledge of a particular area, sit on the committee.

Joan Marshman, the committee's present chairman, says every scientist brings his own set of ethics to an experiment. But "the committee process that involves people external to the institution ensures that there are fewer biases from people in ARF".

Lay members ensure that intricate scientific procedures are described in language the subject understands. They help the committee interpret the importance of clinical research to the public, and lend a greater openness, and appearance of openness to the committee, than if it were composed entirely of scientists.

'One examiner policing another examiner as he examines their subject.'

Lawyer Peter Harris defines the status of the law on the rights of subjects and clarifies the liability of the foundation and the experimenter.

It is becoming impossible for a scientist to get funding for an experiment, without its passing through an ethics committee, Dr Glaser says. Yet the composition and functions of ethics committees differ widely.

For example, Dr Glaser says the separation of scientific and ethical reviews at the ARF is done "for administrative reasons, to prevent too much burden from falling on the ethics committee".

Other research institutions combine the reviews because they say separation indicates a false difference of concerns. Or if the relationship between science and ethics is understood, then two committees end up doing the same work.

Dr Marshman says more experiments are coming under the jurisdiction of ethics committees. At the ARF, the group is becoming stricter as more risks of drugs are revealed.

"We know more about the toxicity of drugs and their side effects than we did five years ago," she says. It is becoming important for scientists administering drugs in an experiment to know that their subjects are not already using drugs, if they want their experiments passed by an ethics committee."

To the charge that review processes hamper creativity, Dr Glaser says: They don't cut down on experiments with people, the experiments just have to be designed more carefully. The committee works with the scientist to help him to be more attuned to ethical considerations.

Dr Marshman says only experiments based on ethical techniques get published and "the world doesn't recognize creativity unless it ends up in published form anyway".

People are very willing to move into scientific communities and say "you can't do this," Dr Glaser says, and scientists should be gathering data to defend themselves against such intervention. For example, the data could support the need for having former drug users in experiments.

If such data is not produced, a jury could find a hospital guilty of contributing to the death of a patient through an overdose, and could put a stop to drug experimentation with patients in a hospital until legislation is passed.

Mr Harris says this situation is more likely to arise in the US than in Canada. In the US, scientists have been more daring, he said, and lawyers will accept as fees a portion of a winning client's court award for injury. Here, lawyers do not accept contingency fees, and scientists have been more conservative.

While there have been several legal rulings in the US on experiments with humans, in Canada, the Halushka case in Saskatchewan is one of the few. The patient won this case, claiming he suffered a cardiac arrest after a catheter the experimenter said would be inserted only in his arm, was advanced toward the patient's heart.

The judge in his ruling defined informed consent. He said a patient in an experiment must have a fair, reasonable explanation of it, and be told the probable effects and unusual risks. The duty owed to patients who volunteer as subjects of a medical experiment is at least as great, if not greater, than the duty owed by a physician or surgeon to his ordinary patients, the judge said.

More legislation in Canada on human experimentation is not desirable or needed, Mr Harris says.

He feels such a step should be reviewed to ensure that the legislative safeguards are preventing real ascertainable abuses. Mr Harris is concerned that some legislation in this area may have been a reaction to imagined rather than real abuses and caused as much harm as the reverse.

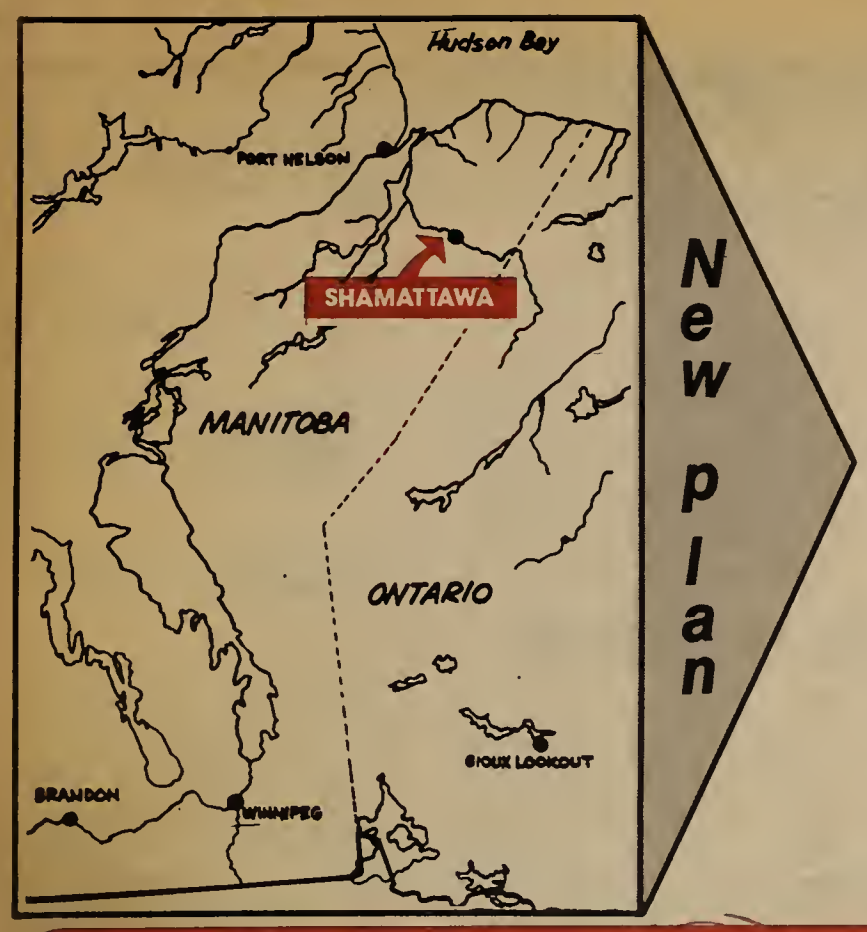
Although Dr Glaser says ethics committees could prevent the need for most legislation in the area of experiments with humans to develop new drugs, in his opinion, Canadian legislation should be initiated to match present US laws.

"The laws in the United States (on developing new drugs) are quite lax, and anything more lax than that is intolerably lax," Dr Glaser says.

Countries without such legislation are having ineffective and sometimes dangerous drugs dumped on them by US manufacturers, he said.

Dr Orrego says he fears similar circumstances would result from the growth of ethics committees in North America and Britain alone. Even as scientists in these places are becoming more aware of risks to humans in experiments, and subjects' rights, dangerous experiments are perhaps being practised instead on people in underdeveloped countries.

THE BACK PAGE



Native gas-sniffing habit brings Ottawa onto scene

By Manfred Jager

WINNIPEG — A community campaign against the critical gas-sniffing problem among native youths at the Shamattawa Indian reserve has been launched with the blessing of federal health and Indian affairs officials.

The plan, announced in late June after approval by the band's chief and council, includes a youth program, a small fishery operation for local use, and the hiring of a community worker.

Two counsellors have been hired by Indian affairs to staff a drop-in and recreation centre approved several weeks ago for the reserve, located about 600 miles northeast of Winnipeg.

The program is the first major effort to combat the gasoline-sniffing problem since it was discovered by Mike Scott of the medical services branch in 1974.

Indian affairs officials originally answered criticism for the two-year delay by saying the decision in May to establish a drop-in centre was the first action the native people had taken to help themselves.

Dr Scott later said he had been instructed by his superiors in the federal health and welfare department not to comment publicly on the Shamattawa situation and to leave all policy statements to Ottawa.

Thirty-seven children from Shamattawa, aged four to 18, were treated at Winnipeg's Children's Centre (formerly Children's Hospital) for lead poisoning caused by gasoline sniffing. This is about twice as many as during the same period in May. Two more youths were found and sent out for treatment several weeks later.

Earlier this spring, a team of Winnipeg doctors tested several hundred young people at Shamattawa for high lead levels in their blood. Two reserve children died in April of pneumonia related to lead poisoning.

In addition to the two or three native people who will be employed to process sturgeon and other small fish from the Echoing and Gods rivers, eight Shamattawa residents have been invited by Island Lake area bands to join their fishing operations.

Four of the eight would fish and the others would work in a processing plant on Savage Island. If the offer is accepted,

(See — Gas — page 6)

The Journal

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World drug misuse

Cutting the demand must be a priority

By Milan Korcok

TORONTO — Drug abuse throughout the world is spreading and only comprehensive efforts designed to cut into demand as well as supply can offer hope of its containment, according to H. David Archibald.

Mr. Archibald, executive director of the Addiction Research Foundation and for the past year on special assignment with the World Health Organization, was speaking to the 11th annual conference of the Canadian Foundation on Alcohol and Drug Dependencies.

"We mobilize law enforcement resources to protect us at our borders . . . but give little more than lip service to the needs for treatment, rehabilitation, research, and education, that would allow us to reduce the demand for drugs."

As examples of this fragmentation, Mr Archibald cited the many international efforts that have gone into breaking up various opium and heroin trafficking networks, while almost nothing of consequence was being done to alleviate the health and social conditions that prompted people to use drugs.

He also chastized various United Nations agencies for hesitancy in perceiving alcohol as a dangerous drug.

"The United Nations agencies have failed, and in a number of instances refused, to come to grips with this problem.

"The World Health Organization has done a little work and presented a few reports, but in relation to the scale of health damage, its response has been totally inadequate.

"The United Nations division of narcotic drugs, which is eager to tackle the problem of opium, heroin, and the psychotropics, has turned a blind eye to the problems of alcohol damage," he said.

Mr Archibald also noted that the Commission on Narcotic Drugs even went so far as to exclude specifically consideration of alcohol problems in spite of evidence of transference of dependence from psychotropics to alcohol and the reverse.

"This is a situation which . . . cannot be tolerated much longer if international organizations involved in this field are to maintain credibility."

(See — Third — page 10)

The latest poster issued by the British Health Education Council to support its anti-smoking campaign is the work of 11-year-old Scottish schoolboy Alistair Cunnison of Edinburgh. The poster now appears on British Railway sites as part of a stepped up promotion effort by HEC.

Addicts rejects methadone

By Gary Seidler

TORONTO — Canadian heroin users are turning away from methadone treatment for their dependence, according to a survey by the federal government's health protection branch.

The decline in the number of people treated with methadone is attributed to the antagonist's lack of availability and the reluctance of the narcotic dependent person to seek methadone or stay in treatment once enrolled.

Concerned about the decline in the number of people in methadone treatment programs between November, 1972, when Canada's narcotic control regulations were amended to control the use of methadone for treating dependence, and January, 1975, the Health Protection Branch established a committee to investigate the status of methadone treatment in Canada.

A summary of the committee's report indicates a Canada-wide trend away from methadone.

While there were 1,703 people enrolled in methadone programs in December, 1972, there were only 1,168 in August, 1975 (latest available figures).

(See — Methadone — page 9)

Female alcoholism is reaching crisis level

WINNIPEG — Alcohol abuse by Manitoba women is reaching crisis proportions, Howard Ferguson, executive director of the Alcohol Family Service Centre in Winnipeg, has warned.

Mr Ferguson said 63% of the centre's caseload of more than 200 families involve women with an alcohol abuse problem and the demand for help is increasing day after day.

"Drug abuse, in all forms, is on the rise and this includes women who combine alcohol abuse with abuse of prescription drugs, like barbiturates and tranquillizers," Mr Ferguson said in an interview.

A Winnipeg spokesman for Alcoholics Anonymous said women in his organization now account for 40% to 50% of the membership.

Five years ago the figure was about 20%.

Deaths of Manitoba women from cirrhosis due to excessive alcohol use have doubled in the past 10 years, while the female population of this province has increased only 6.5% during the same decade, according to figures obtained from Statistics Canada.

In 1974, the last year for which statistics are available, 15 Manitoban women died from the liver disease due to alcohol abuse. Many more could have gone undetected, a Statistics Canada official said.

Jim Burdick, director of research for the Alcoholism Foundation of Manitoba, said more detailed figures on female alcohol abuse in Manitoba aren't available now but his group is working on a study which should be finished in a year or two.

Mr Ferguson acknowledged that "many women hide it and hide it well" and are more reluctant than men to admit a problem.

His group is reaching out into residential areas of the upper socio-economic population groups and is finding a great many middle-class housewives with "a problem they are just starting to admit".

(See — Many — page 6)

Inside this month

Walter Nagel reports from The North American Halfway House conference

Therapists 'too judgemental'

EDMONTON — Therapists should revise their view of alcoholism if they really want to help their patients, an authority on drinking problems has urged here.

R. Keith Simpson, an osteopath from Des Moines, Iowa and vice-president of the National Council on Alcoholism in the United States, suggested many "health workers" are too judgemental about clients who suffer a relapse after treatment.

Most enlightened therapists concede alcohol abuse is a chronic disease state, but many of them don't act rationally in the light of that knowledge, Dr Simpson told the 11th annual conference of the Association of Halfway House Alcoholism Programs of North America, Inc.

He termed it "nonsense" that many workers adopt a critical and punitive attitude when recovering alcoholics occasionally lapse and drink again. Those who suffer other kinds of chronic and sometimes-recurring illnesses are not treated in the same judgmental fashion, he explained.

"A slip or an exacerbation" is commonplace in a chronic disease state, and does not necessarily indicate ineffective treatment, he said.

Dr Simpson said the recovering alcoholic should properly be seen in terms of his former lifestyle, in six- or 12-month blocks of time. If drinking episodes are thinning-out in terms of frequency or severity, that is obvious progress.

Moreover, Dr Simpson said, relapse patterns are overwhelmingly predictable, for reasons still not entirely clear.

"Danger periods" at five to seven weeks after the last drink, at five to seven months, 11 to 13 months, and 18 to 22 months have been confirmed by too many investigators to be mere coincidence. In fact, they have been confirmed in about 80% of cases, in a random sampling of about 10,000 former alcoholics, he said.

Professor of medicine, and founder and chairman of the department of community medicine and social health care at the Des Moines Osteopathic College, Dr Simpson said he is considering collaboration on an international study of the phenomenon of predictable relapse periods among alcoholics. If the project gets under way, some Canadian work is likely to be included.

Dr Simpson said he is greatly concerned about therapeutic attitudes toward recovering alcoholics as the health team expands to include disciplines which do not have a long professional history, or a lengthy acquaintance with the realities of chronic disease conditions.

He cited as one example the idea that it is possible to teach former alcoholics to be "social drinkers — which is an undefinable term". Proponents of that notion acted from high motives, but were basically uninformed, and so they were dismayed "at the disasters which can occur," Dr Simpson commented.

"And when the damage has been done, they (the therapists) get off scot-free."

He called such a process a therapeutic flight "from reality to irresponsibility".

"The person who has a genuine therapeutic relationship with a patient must utilize the proven and effective methods that offer the most hope and protection for the patient. That's the whole basis of the relationship."

MDs may make alcoholics sicker

EDMONTON — There is a growing realization that "so-called minor tranquillizers" should not be used routinely in treatment of alcohol abuse, says R. Keith Simpson.

They can and frequently do produce "a full-blown barbiturate-like dependency" and are not safe and harmless drugs, Dr Simpson said in an interview with **The Journal**.

He said that for the past decade, his view has been that the use of such medications in patients with alcoholism, "is tantamount to malpractice".

"If anything, you run a risk of making the patient worse." There are many citations in clinical literature now that alcoholics are more apt to exhibit exacerbations after use of such drugs, he said. "Plus you run the risk of transferring a dependency."

Dr Simpson said that he, unlike many other health workers, is attracted to working with alcoholics because recovery rates are excellent compared to results in other types of chronic illness.

"It (alcoholism) is not a hopeless entity. I chose to leave my practice in internal medicine and take care of patients with alcoholism because the recovery rate is so much higher.

"It's not a matter of being a dedicated humanist. It's wanting to involve myself in a treatment scheme which results in a higher rate of recovery. The patients with alcoholism — once they do get it back together again — are generally better both physically and mentally than the average person one meets on the street."

Good treatment programs, he said, commonly have 75% to 80% of patients "in that recovering process — the (drinking) episodes are getting farther and farther apart, and shorter and shorter in duration.

"That means — if we were measuring arteriosclerotic heart disease, anginal episodes, or whatever other chronic disease state — that the patient is recovering, doing better and better."

50% of suspended drivers defy courts by motoring to weekly lecture sessions

EDMONTON — A special course for impaired drivers in Alberta is intended to "start people thinking" about their drinking — but some of those attending are defying suspension of their motoring licences to attend the weekly lectures.

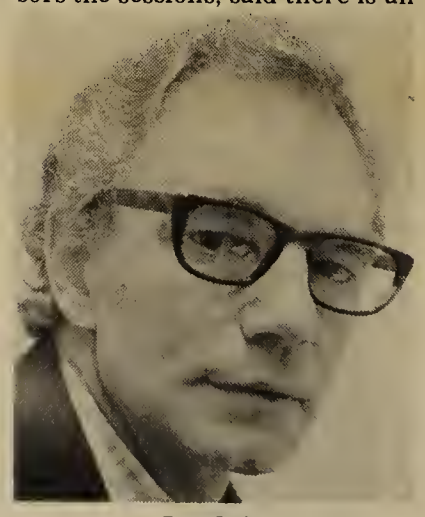
Ron Bailey of Edmonton, co-ordinator of the project, told a conference here that as many as 50% of suspended drivers are believed to drive on occasion, in defiance of a court order forbidding them to do so.

The problem has become so serious that one judge, in a small town near Edmonton, is frequently handing out 21-day jail terms to anyone caught driving while suspended.

"We think many in the course (for impaired drivers) actually drive to the lectures. They'll take that chance," Mr Bailey told the 11th annual conference of the Association of Halfway House Alcoholism Programs of North America, Inc.

People are referred on a mandatory basis by the provincial transport department, or the courts, after they are convicted of impaired driving, for a series of four lectures intended to show the consequences of the offence.

Cliff Pope, an official of the Alberta Alcoholism and Drug Abuse Commission which sponsors the sessions, said there is an



Ron Bailey

increasing referral of drivers who appear to have a growing problem with the use of alcohol. This early detection sometimes forces "the problem drinker — the coming-on drunk" to take the course as a requirement for keeping or regaining a driver's licence.

The two AADAC officials said investigations often reveal such people have a severely disrupted lifestyle. In some cases, they are "just about living in their vehicles".

The four-session course is now available at more than 30 locations throughout Alberta, including several Indian reservations and some high schools. It is offered one night each week, for a period of four weeks, so people may attend after work. An average course involves 75 to 80 people.

The instruction is "absolutely free — the only thing you have to do is be impaired, spend about $250 in fines and appear in court, and so on," explained Mr Bailey.

The emphasis, however, is on education, not punishment, he added.

"We just want people to stop and think, before they get behind the wheel while drinking."

Mr Bailey said most drivers are surprised when told that more people are killed and injured by impaired drivers than by all other kinds of criminals together. In fact, they are astonished in many cases to learn that impaired driving is a crime.

Credibility and trust seen as essential

EDMONTON — A willingness to help people, and less emphasis upon the building of bureaucratic power structures, is the secret of excellence in halfway house programs, a conference has been told here.

James E. Carroll, president of the Association of Halfway House Alcoholism Programs of North America, Inc., told the group's 11th annual convention it is time to get back to essentials if residents are to receive maximum benefit from such institutions.

"It's not a question of who should be in control. What we need is trust and credibility — that is accomplished by honest open methods," he told the meeting.

Mr Carroll made it plain he is not enthused by such emerging issues as certification of staff, accreditation, and licensure.

"The complexity can be overwhelming. There is a constant source of new policies, new regulations, new and revised standards, wonder therapies, wonder drugs, plus complex methods and theories."

The one-time insurance executive and former alcoholic, now co-ordinator of community resources for a state psychiatric hospital in Connecticut, urged his colleagues to remember their primary function is to help recovering addicts re-establish themselves in society.

"We could all use a course in fundamentals, and a brush-up on keeping it simple. But our big problem is how to sell the concept to many of the people in the field who have no idea of what we mean.

"Part of the problem is the power struggle that is taking place in alcoholism and the human services area of which we are part.

"Power struggles will not help our halfway house residents.

"Somehow we must gain back the trust and credibility that is now lacking in our society. Let's be ready at all times to be tested," he said.

...For word groupies in social science land

By Wayne Howell

CERTAIN WORDS, like certain people, have that indefinable star quality about them. They become word-biz legends: as soon as you spot them you know they are on their way to the top — the Robert Redfords of the Gulenberg galaxy.

'Viable', for instance, was just a utility adjective waiting on nouns in an old botany textbook until it was spotted one day by a noted producer of big budget social science productions, screen-tested in a low budget monograph, and then thrown into a leading role on an international symposium stage.

The rest is history — viable alternatives, viable programs, viable solutions, viable this, and non-viable that. Viable became the darling of the social science crowd, and the sweetheart of the media and the politicians.

Then there was 'modality' — an unknown noun, a pale and unpromising understudy of 'mode' until it burst upon the scene in its never to be forgotten debut at a psychology seminar in Topeka, Kansas. Now, of course, it is a grande dame of the lithographer's Lyceum, as respected and admired as 'parameter' and 'multiphasic', as loved and esteemed as 'multi-disciplinary', 'interface', and 'infrastructure'.

But hark, word-groupies out there in social-science land, for the squealing and the swooning is about to start anew. There is a new star on the horizon. It made its unassuming debut at the recent National Drug Abuse Conference in New York City. The word — well perhaps I should present it without further adieu lest I be accused of being a paid publicity flack — is NON-DYSFUNCTIONAL. Admittedly, in New York it was limited to playing a supporting role to that famous old noun 'society' but it is obvious that next time around this word is going to step out as a star in its own right because it is unquestionably loaded with talent.

It has, for instance, pleomorphic potential. This word is too good to be stuck forever in adjectival roles. It is a natural as an adverb. It can — and I predict that it will — play verb roles in the near future; we can look forward to programs non-dysfunctioning poorly. And it is a cinch to grab some starring noun roles. We await with anticipation a learned paper on multilateral societal non-dysfunction. In short, any writer or producer of speeches can play fast and loose with the word, which means stardom is just around the corner.

Not only is it capable of playing many roles, this ingenue is capable of getting along with established buzz-word stars. One can see, for instance, someone requesting funds for a program which has proven to be 'a viable non-dysfunctional treatment modality'. Or explaining away a wasteful or inefficient project because of the lack of a 'non-dysfunctional methodology'.

But the best is yet to come.

Non-dysfunctional is more than some petty nega-positive such as nonresponsiveness or nonproliferation. It is a negated negative. In other words, whatever confusion is manifested by the 'dysing' of 'functional' is compounded — both qualitatively and quantitatively — by the 'noning' of the 'dysing'. This, ultimately, is what gives 'non-dysfunction' that special star quality that will lead it on to bigger and better roles in the literature of the social sciences — the average Joe won't have a clue as to what it actually means.

(Wayne Howell is an Ottawa physician and freelance writer.)

New Brunswick is closing in on alcohol

FREDERICTON, NB — Indications are that before summer is over, parts of the Treatment of Intoxicated Persons Act, passed by the Legislature here in mid-1974, will be proclaimed by the government.

This was indicated in the House in May by Health Minister G. W. N. Cockburn, who said he hoped to have the province's Permanent Commission on Alcoholism established in a few months.

Part of the delay in proclaiming the Act has been due to the need to provide a chain of detoxification and observation centres, located in strategic communities, as required by the legislation. This stumbling block has been removed with the opening June 1 of the last of these centres in Moncton.

Centres have been established in Saint John, Newcastle, Bathurst, Campbellton, Edmundston and Fredericton. The Moncton centre, situated in the old Dr Georges Dumont Hospital, supersedes the treatment and rehabilitation services provided by Foyer Inc., deemed insufficient in terms of beds and space for the area served.

The Moncton centre is on the second floor of the Dumont Hospital, and provides 16 treatment beds — 13 male, three female — a group discussion room, a recreation room, a dining-room lounge, and storage and office space. There are two three-bed rooms (one for females) and 10 two-bed rooms.

Staff consists of a unit director, nine alcoholism attendants, and a secretary-clerk-stenographer.

An out-patients facility is located on the first floor, together with administrative offices.

Arthur Young, executive director of the Alcoholism Programs Division of the department of health, says negotiations for a regional director for the program have been completed, and a person will commence these duties on September 7.

In addition, a competition has been held for counsellors to work in the area program. Mr Young says a final decision as to whether three or four counsellors will be employed has not yet been made, but selections will be made by the end of June and those taken on staff will commence work in early August.

Under the provisions of the Act, a police officer may take an intoxicated person to an observation centre, where the individual may be held for not more than 24 hours.

Three apprehensions in a state of intoxication in a three month period can result in committal to a detoxification centre. The act provides for review procedures and committal requires an order of the courts.

Court orders may also be sought by relatives of people with an alcohol problem, but safeguards are provided by virtue of the fact that again a court order is required and a judge must be convinced of the need for treatment.

Mr Young says that with respect to proclamation of the Act, his recommendation will be that this is carried out in stages. "I would prefer only parts to be proclaimed, with the complete phase-in taking about one year."

Mr Young says initially he would wish the short term treatment and observation sections to become effective.

"This would cover the 24-hour detention provision and basic detoxification. Next, would come the sections providing for detention and treatment to a maximum of seven days, with the final stage being the provisions regarding detention and treatment for up to one month." This latter relates to three apprehensions during a three-month period.

With the provincial government being criticized by some for having permitted too many licensed outlets and made alcohol too available to New Brunswickers, reaping most substantial profits in the process, it is likely that the steps necessary to create the Permanent Commission on Alcoholism and proclaim the Intoxicated Persons Act will receive priority, as the government moves to blunt the criticism.

Valium as a drug of abuse -in second place

WASHINGTON — Heroin continues to account for the largest share of drug-related deaths recorded by this country's Drug Abuse Warning Network, DAWN.

The data collection system, keyed in to more than 1,200 hospital emergency rooms, crisis centres, and coroners' facilities, is a cooperative venture of the Drug Enforcement Administration, and the National Institute on Drug Abuse. (NIDA).

DAWN's most recent report, issued in July, also shows that alcohol in combination with other drugs, and barbiturate sedatives as a group, are next only to the narcotic analgesics in contributing to drug-death rates.

Of the 266,880 drug mentions cited in DAWN's report for the period April 1974 to April 1975, more than 12,000 chemicals were involved in the deaths of 7,196 patients. In 87% of these patients, death was attributed to overdose. Of these drug mentions, heroin/morphine was noted in 15%, methadone 9%, alcohol in combination 13%, secobarbitol 5%, and pentobarbitol and phenobarbitol 3% each.

One of the most prominent characteristics of the DAWN system — a characteristic that has been criticized from within NIDA as well as the National Institute on Alcoholism and Alcohol Abuse (NIAAA) — is that crises related to alcohol only are excluded from the reporting system. Only when alcohol is taken in combination with another drug does it show up in DAWN data.

Only a part of DAWN's reporting mechanism relates to drug deaths. Hospital emergency rooms, inpatient units, and crisis centres involved in the DAWN system report on all cases in which drug use requires some form of help or treatment.

DAWN data is complicated by the fact that hospital emergency rooms account for such a large segment of the reporting activity.

Approximately two thirds of all drug mentions are provided by emergency rooms. And of the 167,075 emergency room drug mentions, Valium accounts for 14%, giving it the top ranking. Among inpatient units, Valium ranks third in numbers of mentions, in medical examiner reports it ranks sixth, in crisis centres it ranks 7th.

Because of this heavy emergency room influence, the aggregate DAWN totals (including medical examiners and crisis centres) — updated to April 1976 — show Valium as the second leading drug of abuse with 9.7% of all drug mentions in the DAWN system, alcohol in combination in first place with 10.4% of mentions, heroin in third with 9.5%, and marijuana with 4.3%.

To curb alcohol abuse

Govt/industry unity urged

TORONTO — The time has come for a government-industry partnership — a dollar for dollar match — to provide a pragmatic and beneficial approach to curbing the abuse of alcohol by youth, says the man responsible for Ontario's Youth Secretariat.

In an address to the Information 1976 conference held here, Terry Jones (MPP-Mississauga) called on the liquor industry to become involved in a more positive initiative to bring about greater understanding of alcohol and the need for moderation.

Mr Jones wrote the Ontario government's youth and alcohol report which recommended raising the legal drinking age from 18 to 19 years, a system of identification cards, and rigid enforcement of existing laws to deal with reckless use of alcohol (The Journal, May).

While the Ontario government is considering a ban on alcohol advertising, Mr Jones holds little hope that elimination of advertising will provide a quick and simple end to a long-standing and complex problem.

"Because we are all exposed to extensive advertising and the perceived wealth it generates, it is a 'safe' scapegoat. But there is little definitive research to prove that advertising actually causes people to drink. Rather, it is more likely that advertising encourages drinkers to change brands," Mr Jones said.

Also, it is possible than a ban on advertising would further add to the mystique or "forbidden fruit" aspect of alcohol, he added.

However, the alcohol industry should not be allowed to get off the hook, according to Mr Jones.

"The messages they beam are often directly aimed at young people coming of age, the new consumers. They deal with the insecurities, the aspirations, and the interests of many young people.

"To equate the consumption of alcohol with the beautiful life is prejudiced and unfair. Proper usage and moderation should and must be underscored in any advertising."

Mr Jones said the sensationalism attached to the use of other drugs over the past few years has been largely responsible for diverting public concern from the longer-lasting and potentially more devastating problems associated with drinking.

Mr Jones admitted the government was far from consensus on the question of the legal drinking age.

"Once the tap has been turned on, it is difficult to turn it off, let alone pour back what has already been spilled.

"Our cities say you can't tell people who are old enough to vote (in Ontario, the age of majority is 18) that they must be older to drink.

"Well, irresponsible voters may do some harm, to be sure. But they don't become addicted. They don't cause suffering and expense to themselves and to others."

While he doesn't believe the age change would provide a magic cure, Mr Jones reiterated the position of his report which emphasized that raising the age to 19 would go far in removing alcohol from Ontario's high schools.

Mr Jones said the recent decisions by both Minnesota and Saskatchewan to raise the legal drinking age "lend support to our recommendation. These two jurisdictions have identified a serious problem and have taken decisive action."

Down goes the gauntlet to alcohol advertisers

TORONTO — A series of steps designed to discourage advertisers from encouraging greater consumption of alcohol has been launched by Canada's Health Minister Marc Lalonde.

In an address to the Information 1976 conference here, Mr Lalonde said he planned to meet this summer with the brewing, wine-making, and distillers' industries, as well as the media, to get industry undertakings to:

(1) confine broadcast advertising to between 9 pm and 7 am;

(2) limit promotional expenditures; and

(3) eliminate lifestyle advertising in print and moderate other types of promotional activities.

Mr Lalonde also announced plans to amend Canada's Food and Drugs regulations to require a warning about the harmful consequences of alcohol use in all beverage alcohol advertising and on bottles, packages, cartons, or other containers.

Also, Mr Lalonde said: "We are asking the Canadian Radio-Television Telecommunications Commission to alter the practices of its beer, wine, and cider clearance committee (which approves broadcast messages) in order to reduce drastically the effects of promotion on the relationship between drinking and apparently desirable lifestyles."

Mr Lalonde pointed out beer, wine, and spirits have been promoted with increasing aggressiveness.

Marc Lalonde

Premature infants exposed to 20 drugs

MONTREAL — The average premature baby is exposed to about 20 prescribed drugs from the time of conception to the time of discharge from hospital.

This is one finding of a study of premature infants in Montreal hospitals. The research team was headed by Allan Neims of the Roche Developmental Pharmacology Unit, McGill University.

In an interview with **The Journal**, Dr Neims said: "The mother (of a 1,500 gram premature baby) will get 10 drugs to which the fetus is exposed. Routine delivery practice will involve another three.

"Again, within routine practice, the newborn will be exposed to seven more drugs because of medical conditions in the premature. This varies but that's an average," he said.

This is not to count, Dr Neims added, caffeine, nicotine, alcohol, lead, and other chemicals in the environment.

"There is a whole lot to be learned. One direction of our research concerns how much of a drug the baby can tolerate and at what developmental stage in the rapidly changing infant.

"A lot of bad things have happened but many side effects — not all of them — are qualitatively predictable as occurring at or pertaining to the time of birth."

Allan Neims

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Warning network on drug abuse neglects alcohol

SINCE JULY 1972, the Drug Abuse Warning Network (DAWN) has been going through a process of expansion, refinement, and sophistication in the US.

It now encompasses more than 1200 emergency rooms, coroners' offices, and crisis centres in 29 metropolitan areas.

Last year, it recorded more than 190,000 individual drug episodes (crises, cries for help, calls for treatment). And since its inception, DAWN has accumulated a vocabulary of approximately 3,000 substances used either alone or in combination with each other.

That kind of data base should tell us a lot about changes and shifts of drug use. But, so long as it neglects to mention alcohol, except in cases where it has been used in combination with other drugs, DAWN's revelations will be of limited value.

It makes no sense that alcohol — which remains the drug of most prevalent abuse not only in North America but throughout the world — should not be accurately recorded in this compendium of drug misadventure.

The fact alcohol is a "legal" drug should not preclude it from the DAWN system since the bulk of other drugs recorded — tranquillizers, barbiturates, analgesics, stimulants, etc. is legal.

The only thing that seems to cut alcohol out of the pack in this reporting system is that its use is so vast and so pervasive that charting its impact seems beyond the capability of our computers.

Somehow, in this age of technological marvels it does not seem rational to consider that as an excuse for avoiding the reality that alcohol kills and disables on a magnitude unmatched by any other chemical. It seems more likely that it is not the lack of technology that precludes the count, but artificial, political, and jurisdictional priorities.

The recent DAWN report shows that alcohol in combination with other drugs was involved in 13% of deaths recorded by that system. What would have been the count if alcohol use, by itself, had been recorded as a source of crisis in the emergency room or the detox centre, or the police precinct!

It would be unfair to single out DAWN as the pre-eminent transgressor in respect to this double standard. DAWN simply reflects a much broader attitude.

In a recent address to the Canadian Foundation on Alcohol and Drug Dependencies, H. David Archibald of the Addiction Research Foundation of Ontario effectively focused on this attitudinal ambiguity when he charged international agencies with promoting the double standard.

He criticized the United Nations Division of Narcotic Drugs for allowing their preoccupation with heroin, opium, and psychotropics to interfere with their concerns about epidemic alcohol use.

"Agencies of the United Nations have been willing to mount aggressive campaigns against international trafficking of opiates, yet they have constantly and in many cases deliberately ignored the problems of alcohol damage."

He also censured the World Health Organization for simply going through the motions in responding to the public health damage caused by alcohol throughout the world.

He warned these and other groups that if they continue to ignore alcohol as one of an arsenal of dangerous drugs, they do so at peril to their own credibility.

The warning is a just and timely one. And though it was aimed primarily at international agencies, organizations such as DAWN should heed that kind of warning.

It is difficult enough developing drug programming priorities when the field is already so chopped up and fenced off. Distorting the information we do have just because it doesn't fit into our computers isn't going to help.

Milan Korcok

Letters to the Editor

More letters — page 11

Pot law

Sir:

Saul Abel's account of the impact of California's liberalized marijuana law ("Good and Bad News from California", The Journal, May 1) tended to dwell on alleged bad effects, while ignoring many of the immediate benefits which the new law has brought about.

Specifically, too much uncritical attention was given to Los Angeles Police Chief Ed Davis' unfounded assertions that the new law is responsible for increased marijuana importation and will lead to a doubling of both the number of heroin addicts and drug overdose deaths in California. The causal relationship between the new law and marijuana seizures is dubious to say the least, and Davis' dire warnings about addicts and overdoses should be viewed merely as indicative of the "reefer madness" mentality which they represent.

The new law has resulted in substantial savings of police time-on-the-streets, as well as a dramatic reduction in the amount of court time being expended on minor marijuana offences. Equally importantly, tens of thousands of Californians apprehended in possession of small amount of marijuana this year will be spared the harsh consequences of lifelong criminal records as well as the trauma and harm which comes from being arrested and jailed.

On balance, a statewide survey of judges and law enforcement officials would indicate that the new law is working very well indeed. Any problems which do exist will be solved in time by further decriminalization and not by returning to stiff criminal penalties, as Ed Davis has urged. That day has passed.

Gordon S. Brownell
West Coast Coordinator
National Organization for the Reform of Marijuana Laws,
San Francisco, Calif. 94123.

Dismay

Sir:

With great dismay and strong feelings of disbelief I read in The Journal (July 1) your editorial "Alcohol campaign too little, too late". Dismay, because when so many people suffer it is never "too late" to find ways and means to prevent that serious suffering in our Canadian society. Disbelief, because several statements in that editorial were so far below the high standard of The Journal in general, that your credibility becomes questionable.

First, I think it is hitting "below the belt" in a dignified journal to suggest "that the prime objective of the campaign is designed to catch votes". I find this a hackneyed kind of interpretation, which could and has been used for all statements made by every politician. Shame on you! Moreover, do you not contradict yourself later by saying "but some other provinces may well resent the fed's attempt to infiltrate what is largely a provincial jurisdiction"? Hardly a way to win votes!!

Second, you state that "there can be little doubt that Canadian Society as a whole is more concerned than it has been for a considerable number of years, with growing alcohol abuse". If this is really true, and I cannot accept it as so, how can you explain the growing "intake" of alcohol, the growing number of offences related to alcohol and the increases of charges against drunken drivers? More awareness, yes, but don't call that more con-

(see page 11)

Backgrounder

The Rand report

By Milan Korcok

THE ALCOHOLISM treatment field may be in for a rude shock if a recently-released report * from the Rand Corporation stands up under scrutiny and is substantiated by further research.

In the past decade, the field has led a complicated life. Detoxification centres, hospital and rehabilitation units, residential and outpatient facilities, and intervention programs have all come to play a part in it — largely on the premise that what works for one alcoholic may not work for another.

Now, this 200-page report, prepared under a grant from the National Institute on Alcohol Abuse and Alcoholism (NIAAA), suggests that premise, and perhaps some others, need a closer look.

Those who believe moderate, controlled drinking is a more realistic goal for most recovering alcoholics than is abstention, will be buoyed by the report's conclusions.

Those who urge continuing diversity of treatment and who believe the secret of successful treatment lies in a more precise match of services to clients, will be frustrated or angered.

The Rand Report, though it does not neglect to emphasize its own methodological drawbacks, is a substantial piece of work and its influence is already being felt by treatment planners.

The report's greatest strength is the size of its subject groups. It's observations and conclusions are based on treatment and intake follow-up data accumulated at NIAAA's 44 comprehensive Alcoholism Treatment Centres throughout the nation.

The survey included approximately 14,000 clients admitted to the ATC's from September 1972 to April 1974.

Six month follow-ups were completed for 2,371 male clients. Eighteen-month follow ups were completed for approximately 600 male patients and another 400 who made contact with an ATC but were not admitted to treatment.

To add a control factor, data were used from four national alcoholism attitude surveys by Lou Harris, which yielded a total of more than 6,000 respondents. This was used for defining drinking practices of the general population and its problem-drinking subpopulations.

Some of Rand's findings:

• Of clients entering NIAAA centres, 70% showed improvement in their drinking behaviors. This means that even if they did go back to drinking, as the majority did, they kept it under control and in fact drank less than the normal population. In terms of volume this was equivalent to four cans of beer, four ounces of wine, or four shots of liquor on drinking days, which was about one day out of three.

About one quarter of the clients interviewed at 18 months had abstained for at least six months.

• Relapse rates were no higher for those alcoholics who had returned to moderate drinking than they were for long-term abstainers. Does this mean that for some alcoholics moderate drinking is not necessarily a prelude to full relapse? Can some alcoholics return to moderate drinking with no greater chance of relapse than if they had abstained?

Perhaps so, says the Rand Report . . . though it adds that it would be far too early in the survey process to directly advocate that alcoholics should attempt moderate drinking after treatment.

A key word in the Rand Report is "remission". This is based strictly on drinking behaviours — social adjustment indicators such as marital status or employment are not included.

• Using "remission" of destructive drinking patterns as the improvement criteria, the survey found that a little bit of treatment, or a particularly short course of it (such as detox), was not much better than no treatment at all. Only when formal treatment was substantial was the remission rate significant — as the difference between the 50% remission rate of patients who took no formal treatment, and the 70% rate of those who did.

• The "fact" that a client commits himself to treatment is more important than is the specific type of treatment — so long as he stays with it. There appears no consistent difference is remission rates among different treatment settings and no indications that certain types of patients necessarily fare better in specific facilities "matched" for them.

What appears more important than this matching are the patients' characteristics.

A patient with sound socioeconomic status, with less severe symptoms, and with a stable social background clearly has a better chance of recovery. But, whether he is placed in an intermediate outpatient facility or an expensive, highly-specialized hospital makes very little difference — so long as the weight of treatment is substantial.

A most intriguing prospect projected by the Rand Report is that formal treatment itself adds no more than 20% to 25% to the recovery chances of an alcoholic.

". . . hospitalization is not substantially more effective for the more severely impaired alcoholic (except where specific medical process is involved); outpatient individual therapy is not more effective for stable, middle-class clients; and intermediate care is not more effective for unstable, low socioeconomic status clients.

A point is the definition of recovery itself.

To some, recovery means the reinstatement of an individual to a life not only without alcohol but with a sound social balance, home, wife, children, job, etc.

In the Rand Report, this is far too cosmic an expectation. These surveys are based on alcoholic remission rather than social rehabilitation. Is a client who once was drinking to the point of damage now able to drink normally, or not at all? Are the symptoms of his drinking relieved?

This kind of definition is bound to antagonize those who believe drinking is irrevocably tied to social and psychological disturbance, and that to treat one — drinking — one must also treat the other — living.

Not necessarily so, says the Rand Report.

The fact remission rates are uniform for the different treatment modes, including AA meetings, tends to contradict theories which claim alcoholism must be treated by dealing with deeper psychological problems.

"Whatever the role played by psychological problems in the onset of excessive drinking — and our data suggest they are prominent — once alcohol dependency or addiction is established it appears non-psychologically oriented treatments work as well as any other method," says the report.

Then the clincher: "In other words, recovery from alcohol dependency may depend on mechanisms quite unrelated to the factors that led to excessive drinking in the first place."

The Rand references to remission as valid indicators of recovery (so long as the remission lasts long enough) is controversial stuff. Critics of the report have already descended in some force to claim that six or 18 months "remission" is hardly the same as recovery. And the Rand authors admit that fact themselves.

They also say: "In accepting normal drinking as a form of remission, we are by no means advocating that alcoholics should attempt moderate drinking after treatment." A lot more research will have to be done before such advocacy can be launched.

"But since we have found no solid scientific evidence that abstainers are more likely to avoid relapse than moderate drinkers, we must entertain the possibility of normal drinking for some alcoholics."

If you keep telling an alcoholic that one drink is as bad as 10, and he believes you, he might never try to stop after one or two.

Throughout the report, the authors emphasize the preliminary nature of their findings and the need for more research. At this point, they say, it would still be unwise to advocate anything but abstention as a treatment goal.

They also admit to some flaws in their methodology, such a relying so heavily on alcoholic self-reports, and having treament personnel from the ATCs so involved in evaluations of their own patients' progress.

NIAAA is also wary of attaching to the findings anything that smacks of their imprimatur, other than an admission that such research can help broaden the overall scientific resource.

As soon as the Rand Report was released, NIAAA director Dr Ernest Noble issued a press release emphasizing that NIAAA was not about to deviate from its policy of proclaiming abstention as the only goal of ATCs.

Albert Pawlowski, chief of NIAAA's extramural research branch told **The Journal** that nothing in the report was going to "revolutionize" NIAAA's approach to alcoholism.

"We must take the findings and build on them," said Dr Pawlowski.

Nonetheless, the findings offer some intriguing prospects for social policy and research.

If the differences in treatment modality and service delivery are relatively unimportant, then less expensive treatment makes more sense. So does broader use of paraprofessional rather than degreed counsellors. And it is only reasonable to expect more use of outpatient care at the expense of more costly inpatient treatment.

There is also much significance in the finding that the effectiveness of treatment can be directly linked to its duration and intensity. This is not a good sign for short-term services.

"Until further research settles the exact causal sequence (of effectiveness), treatment programs should de-emphasize short-term treatment such as detoxification, and emphasize longer term treatments, especially those in outpatient settings."

And given the possibility that alcoholics might return to normal drinking, the report suggests research should give a heightened priority to finding those physiological or psychological signals that might differentiate between alcoholics who can return to normal drinking, and those who cannot.

**Alcoholism and Treatment* — The Rand Corporation, 1700 Main St., Santa Monica, California, 90406.

Inside Science

Dr Adrian Wilkinson, a clinical psychologist with the Addiction Research Foundation on Ontario, discusses the use of group contingent reinforcement for the production of a therapeutic environment.

IT IS the responsibility of the staff of any treatment unit to maintain an environment in which the opportunities for desired therapeutic change are maximal.

In a unit for the treatment of drug dependence, there is prima facie evidence that the use of drugs on the unit is disruptive and disconcerting to fellow patients whose treatment goal is to abstain from continued use. In any treatment setting, the use of violence and the destruction of property are likely to be considered undesirable, and a variety of implicit and explicit expectations will exist about the sorts of patient behavior that will contribute to or impede therapeutic progress.

Young multiple drug users very frequently have a history of problems of adjusting to the demands of institutional social settings. These problems are exemplified by their acting out in school, and previous hospital admissions.

A problem confronting the staff of units treating such patients is how to engender a safe, orderly, and therapeutic environment without adopting a policing role which is likely to interfere with the cooperative relationship desirable between therapist and patient for the maintainance of therapeutic progress.

The solution adopted by the staff of the inpatient drug ward in the ARF's Clinical Institute, has been to develop an administrative system by which the patient group is made responsible for the regulation of its own behavior.

The procedure by which the patients of the unit are made responsible for regulating their own behavior is to make various 'privileges', which the patients are presumed to want, contingent upon the patient group's success in abiding by the rules of the program.

A committee of the staff, working with the patients, developed a set of rules of behavior. These included such items as proscription of physical violence and drug use on the unit, maintainance of a clean and reasonably tidy environment, punctual attendance at program functions, and adherence to smoking regulations prescribed by the fire marshall.

Points were awarded daily for the group's adherence to these rules and the number of privileges available was contingent upon the number of points the group had earned the previous day. Privileges included free soft drinks, access to television and tape deck, and passes out from the hospital.

When the points system was initiated, a remarkable feature of the group's behavior was the ease with which patients managed to change what they reported as the habits of a lifetime. An average of one rule per day was broken by the group, all of whose members were punctually present for almost all program functions. The rate of rule breaking was maintained at a level which ensured that passes (the most costly privilege at 15 out of 17 possible daily points) were available for 80% of hospital days.

To test the effectiveness of the group contingencies in maintaining a therapeutic environment, privileges were made non-contingent on group points for a period of three weeks.

The patient group had chronically complained about the system of group contingencies and were delighted by their removal. They extracted from the staff an agreement that the group contingencies would not be reintroduced after a three week trial if the rate of rule breaking did not change during the trial period.

The result of the removal of the group contingencies was that the rate at which rules were broken more than doubled. Within two weeks, I received a deputation of patients requesting the system be reintroduced ahead of schedule because the therapeutic atmosphere of the unit had allegedly deteriorated so much.

Rates of drug use on the unit and on pass, and of violent acting out, increased between three and sevenfold. The mean duration of stay on the unit decreased from 25 to 15 days, and the staff had increasingly to resort to the threat of discharge from the program to control the behavior of individual patients.

When the group contingencies were reintroduced, the rate of rule breaking and duration of stay rapidly returned to baseline levels. The results clearly demonstrated the power of the group contingencies for maintaining a therapeutic environment.

Multiple drug users are a group with poor impulse control. The results of the present study demonstrate that structuring quick and reliable consequences for desired and undesired behaviors can significantly reduce the frequency with which impulsive disruptive behaviours can interfere with the effective conduct of treatment, and the application of contingencies to the group ensures that the group adopts responsibility for regulating its own behaviors, freeing the staff from disciplinary roles so that they may act more effectively as therapists.

Alcohol has 'fiendish dual function'

By Dorothy Trainor

MONTREAL — Despite the efficacy of antidepressant drugs, the psychiatrist is helpless to cure the alcoholic of his depression.

"It is absolutely necessary to treat the alcoholism first and then get at the depression," Heinz E. Lehmann told a McGill University symposium on depression held at St. Mary's Hospital.

Dr Lehmann is an international expert in the area of depression and is director of research and education at the Douglas Hospital, Montreal.

"Many chronic alcoholics are alcoholics because they are basically depressed. In them, alcoholism has a fiendish double function. They drink for instant relief from the intense and continuous nature of their depression and, secondly, through a desire for self destruction which alcohol serves very well."

Where such pressures reinforce the need to drink, he said, it is very difficult to get people to give up their refuge and develop sobriety. Hence, a very large group of people does not receive treatment for depression.

This constant pattern of drinking, he said, prohibits treatment with the usual drugs, i.e. tricyclic antidepressants (such as amitriptyline and imipramine) or MAO inhibitors (such as Parnate and Nardil) as drug interactions make the side effects too severe.

"Sometimes it is possible to make a therapeutic contract with the alcoholic to stop drinking while receiving treatment, but this happens only in a minority of cases. And even though the contract is made, they don't always stick to it."

Once the drinking problem is solved, it is easier to get at underlying reasons for the depression which was served and fostered by alcohol, said Dr Lehmann

Heinz Lehman

Options to intoxicant use

Alberta plan concentrates on living skills

CALGARY — An innovative program to enhance personal living skills as an option to intoxicant use, has received the acclaim of education officials here.

Ken Low, co-ordinator of drug information for Calgary's public school system, contends the focus of agencies like his own should change from providing mere facts about specific intoxicants, to offering ideas about other satisfactions available to young people.

There must be more consideration of the reasons alcohol and non-medical drugs are used, Mr Low told trustees of the Calgary Board of Education, at a recent meeting.

Mr Low received the unanimous support of trustees when he proposed that his drug information efforts be entitled "action studies", and that he continue experimental work during the next two years on programs that offer non-drug activities to pre-schoolers and students.

"The history of drug education' has been a very sad one," agreed Bruce Johnson, chief of curriculum planning for the CBE.

"We have happened on an approach (Low's latest proposal) that will apply to many areas, including drug and sex education."

"Action studies has become the fundamental approach of the drug education team," Mr Low commented in recommendations to the board.

"The objective is the development of basic personal competence. This is in line with the over-all objectives of the (school) system, and there are more basic reasons to seek this objective than the prevention of intoxicant problems — which is the only one type of problem avoided through personal competence."

Mr Low said he and his staff "... feel there is a significant need to continue the action studies program development, as a complement to other endeavours in the basic mission and responsibility of the public school system".

Drug education, he added, "should remain a listed and identifiable sub-specialty of action studies".

A detailed printed report presented to the school board, said a three-year project was begun in September, 1972, to examine possibilities for enhancing students' abilities to make and carry out "wide-decisions" in their personal living patterns.

"It was reasoned that such a capability is fundamental to being able to avoid problems with intoxicants."

Mr Low explained that the issue of intoxicant choices was not a priority so much as was an understanding of personal responsibility and perceptions of worthwhile experience. Most drug education programs then current were emphasizing the nature of intoxicants, assuming that ignorance on that point was the reason that drugs and alcohol were being abused. Programs which failed to move beyond that level now mostly have been abandoned as unsuccessful, he remarked.

"The roots of intoxicant problems go much deeper than most people imagined."

Key parts of the Calgary project were in-service training sessions for a few teachers willing to instruct "life skill" option courses, and two experimental "experience and activity" undertakings for children of both preschool and student age groups.

Three courses for teachers, although only small numbers were involved, "tightened up the concepts and clarified the role of activities in developing basic competence," Mr Low said in his report.

"By this time the value of wilderness and city survival/adventure programs was apparent, although the theoretical connections were still somewhat vague."

There was emphasis upon teachers themselves acquiring action skills, with the rationale that people must develop competence before they can teach others how to do likewise.

"Action studies options were offered in a number of different junior and senior high schools. The character and format of these courses varied considerably, depending on the teacher and the state of development of the over-all ideas and techniques.

"Early efforts tended to be activity programs. Later efforts stressed communication and information skills; only the most recent efforts cover dimensions of action."

Mr Low told school board trustees he has "very little doubt" development of personal competence through programs such as these tends to help them avoid intoxicant problems.

" . . . We have partially developed prototypes and a fairly good picture of where we need to go from here," he suggested.

"Personal competence is not an automatic result of serious educational endeavour, nor does it necessarily follow from conventional standards of child-rearing and family life. It is suggested that personal competence can be systematically developed by families and schools, but only if we consciously make an effort to do so," he said.

"It is worth doing for far more basic reasons than enabling people to avoid problems with intoxicants."

Spaced-out grandmas are ignored

BERKELEY, CAL. — While adolescent drug abuse commands widespread attention, medicine has turned its back on the equally serious problem of drug abuse among the elderly, says a Berkeley psychiatrist.

There is a growing horde of ancient chemical hippies in the US who owe their "spaced-out" status to the good intentions of their family doctor, says Dr Wendell R. Lipscomb.

The "spaced-out grandma" syndrome comes about when a patient is treated for several conditions with a combination of different drugs, and the total effect of the therapeutic cocktail is not considered, says Dr Lipscomb.

What results is an iatrogenic psychosis.

"It is a syndrome that one might expect to find in a youthful hippie drug experimenter," he adds.

And psychiatrists are beginning to see an increasing number of these patients.

The typical patient is a woman in her 70s who has been treated for multiple ailments — arthritis, hypertension, obesity, periodic headaches, sleeplessness, and mood swings — each complaint being treated in a cookbook fashion with a drug for each symptom.

Another related problem is the abuse by the elderly of non-prescription over-the-counter drugs advertised as sleeping aids, calming agents, or tranquillizers.

Many such medications can lead to the "spaced-out grandma" syndrome and even temporary commitment to a mental hospital.

In Manitoba

Many alcoholic women remain undetected

(from page 1)

Mr Ferguson added: "Now they know where to go for help, whereas before they were less likely to be discovered and therefore less likely to admit a problem."

The Alcoholics Anonymous spokesman said it's this group of women which needs to be reached and understood because "their problems and needs are very real indeed".

Women with alcoholism problems aren't only getting more numerous, they are getting much younger, said Bill Marshall, director of program development for the foundation. Ten years ago, the average age for women alcoholics was over 40. Now teenagers and women in their 20s are becoming the most numerous, said Mr Marshall.

A woman alcoholic with Alcoholics Anonymous said young women are attending AA meetings at 18 years of age with drinking problems that started at age 12 or 13.

Experts in the field cite the changing role of women in society, the increase in divorce, and the tensions of modern technology in society as reasons for the increase in female alcohol abuse. They say more research is needed, however, before it will be possible to pinpoint alcoholism causes in women.

"Women traditionally face a rougher time and different problems than men, such as there being more of a stigma attached to women alcoholics than to men," said the AA official.

As well, it is often harder to treat women alcoholics because they might have families to look after and consequently are not as able to spend time on treatment.

"When women do receive treatment they are often treated like men and are assumed to have the same kinds of problems men have.

"That's a big assumption . . . and perhaps a wrong one as well," said the AA official.

Added to the problems of the female alcoholic is the fact there is a critical lack of adequate treatment facilities for women in Winnipeg and the situation will get worse as time goes by, Mr Ferguson predicts.

At present, the Alcoholism Foundation runs River House, a halfway house for women and there are women's AA groups in Winnipeg.

Mr Ferguson said there is special need for out-patient facilities for women with children.

He said women from the middle- and upper-class areas need their own kind of facilities in their home areas. But nothing is available.

"They don't want to spend their time in the detoxification centre downtown. Like most people, they want to be with their own kind and only in this way will they feel comfortable and be more receptive to treatment," said the executive director.

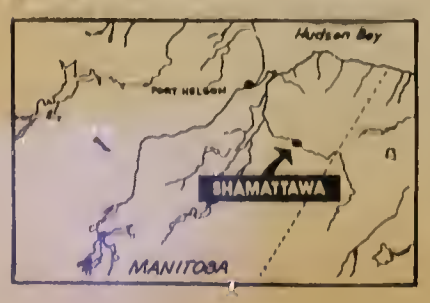
Shamattawa reserve

Gas-sniffing children draw attention

(from page 1)

Indian affairs will arrange the temporary relocation of the workers' families.

The band also plans to begin a nursery and kindergarten this fall in a home on the reserve, now partly owned by the federal government.



The youth program will initially involve the hiring of between 15 and 20 native youths between the ages of 15 and 25 years by Indian affairs to begin a major clean-up campaign on the reserve.

The workers will dig garbage sites and collect and paint the numerous 45-gallon empty drums scattered around the reserve for use as garbage containers.

All equipment for the program and materials required to renovate a building to house the new drop-in centre will be supplied by Indian affairs.

Art Schwartz, of the federal health department's medical services branch in Winnipeg, said the Shamattawa band council along with federal and provincial officials "are all working together in a united effort to see what we can do to solve the gas sniffing and other related social problems at the reserve.

"There are quite a few things in the process of happening right now at Shamattawa," he said. "There now is great awareness of the seriousness of it by a very major percentage of the community."

Dr Schwartz said medical services and Indian affairs officials had met frequently with the Shamattawa chief and band council to expand community involvement in the new programs. He added that officials are "in the process of forming a province-wide steering committee" involving federal, provincial and children's aid workers.

"It's a very slow process," he said. "It's fine to say something ought to be done, but what the hell can you do?"

No tests for symptoms of gas sniffing are being administered on the reserve at this time, but Dr Schwartz said "virtually every youngster there has been tested recently".

11th Annual Conference of the Canadian Foundation on Alcohol and Drug Dependencies

INFORMACTION 1976

Abstinence lifestyle should get 'fair hearing'

SELF-RIGHTEOUS attitudes of temperance individuals and organizations have seriously harmed the case for abstinence as one solution to the world's pre-occupation with alcohol.

Rev David Reeve, executive director of Alcohol and Drug Concerns Inc, in Toronto, said the subject of abstinence has never before merited objective consideration as a solution to the alcohol problem. However, mounting concern over alcoholism may finally allow this particular lifestyle to be given a fair hearing, he said.

"It is reasonable to assume that a much larger number of people within a country could be persuaded to avoid the use of a product that is not a food, is not a medicine, that impairs good judgement and perception, and in quantity is toxic and debilitating," he told a session on treatment theories and techniques.

Mr Reeve recommended the formation of a voluntary group of non-users in Canada who would "be willing to identify themselves as such and who would without any superior or judgemental attitude toward those who follow a practice of responsible drinking, organize in a totally voluntary way for friendship and the pursuit of mutually established goals.

Such a group, he continued, would organize in the same manner as Alcoholics Anonymous and would:

- not use alcohol and recommend this lifestyle only when asked;
- represent the interests of non-drinkers in requesting that non-alcoholic drinks be served in all places where alcoholic beverages are available;
- seek to develop the awareness of the 50% of the population who use small amounts of alcohol but who pay for the social health costs of the 10% to 25% who are heavy consumers; and
- publicize the benefits of good health, weight control, safety, and family well-being that results from sobriety.

"Such a step need not wait for further research or organizational development."

Canada's drinking drivers

Tougher police action urged by NS official

IT IS not new laws and new programs so much as it is more rigid enforcement of existing ones that offers hope of containing Canada's drinking drivers, says Ernest Pass, Director of Highway Safety, Nova Scotia ministry of motor vehicles.

Mr Pass urged use of mobile breathalyzer units at roadsides, more imaginative police placement of spot checks (such as outside liquor outlets), and mandatory education/rehabilitation programs for convicted drinking drivers.

He also recommended more strict relicensing procedures for convicted drivers, more effective propaganda to warn the public of the risks in contravening drinking laws, and a reduction of legal blood alcohol concentration levels to 0.05%.

He said Canada experiences almost 3,000 deaths annually in alcohol-related auto mishaps, and said this costs some $360 billion ($120,000 per fatality).

To combat this situation, he said, detection methods, now primarily geared to picking up the grossly intoxicated driver, need to be upgraded.

Roadside detection programs in Nova Scotia have shown that the average blood alcohol content of drivers convicted under breathalyzer legislation was 0.17%, almost twice the legal limit.

Once a system of mobile detection units was implemented and the activity publicized, average BAC levels of those convicted dropped to 0.15%, said Mr Pass.

The relicensing of drivers after conviction also demands a tougher approach, he said.

The driver should be asked what he has learned by his conviction and subsequent retraining and how his drinking behavior has changed, said Mr Pass.

"The courts . . . have demonstrated that they have neither the time, the inclination, nor the interest to become involved with . . . problem drivers other than to hear the evidence of the case at hand and . . . determine if an offence has or has not been committed, dispose of it, and move on to the next case."

He said in Nova Scotia, repeat offenders undergo more rigid investigation. Any driver convicted of an alcohol-driving offence applying for a new licence has his record reviewed.

If the record shows three confirmed or suspected alcohol-driving involvements within 10 years, that driver must submit a medical report for review by a medical advisory committee.

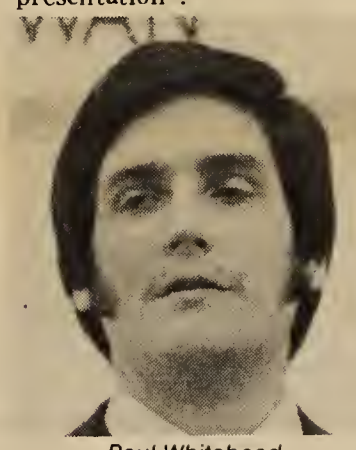
The province has also made use of conditional licences which prohibit a driver from driving at specified times and places. Renewal of the full licence was contingent upon favorable follow-up reports during this conditional period.

(These part-time prohibition orders began to be issued by courts in Nova Scotia in December 1972 and continued to be issued until November 1973 when the Supreme Court of Canada ruled them invalid. During the period they were issued, there were increased numbers of court convictions.)

In the overall Canadian experience, said Mr Pass, too many convicted drivers are being granted restoration of their licences without any real attempt to evaluate post-conviction progress of the individual or his involvement in counselling.

Court referrals to education/rehabilitation programs have not proved effective, he said. Experience shows that courts either don't refer, or refer only those with the most obvious problems, who are the ones with the least chance of recovery.

He also noted most educational programs for convicted drivers in Canada today are "totally didactic, authoritarian, and threatening in presentation".



Paul Whitehead

He urged that drivers who decline such education programs should be denied licences.

Many drivers convicted of drinking offences have more deep-seated problems with alcohol, he said. Nearly one out of three drinking drivers convicted of offences are problem drinkers.

"Uncompromising measures against a person who may be struggling with the problem of alcohol addiction may seem drastic. However, in the long run, this restriction may have more of a salutory effect rather than a detrimental effect on this individual."

The recommendation to lower legal BAC levels received further support from Roberta G. Ferrence of the Addiction Research Foundation, in London, and Dr Paul Whitehead, chairman of the department of sociology at University of Western Ontario, and a consultant to the ARF.

Their paper noted that because variations often occur in measuring BAC readings, it is rare for a charge to be laid against a driver with less than 0.10% BAC. In fact, the average BAC for drivers convicted is closer to 0.15% they said.

They recommended lowering the legal BAC to 0.04%, which would mean that few charges would be laid at readings less than 0.06%.

Besides supporting measures to increase police powers in roadside random screening (whether or not police have evidence or even suspicion of impairment) the London researchers urged setting up detection screens in high probability areas during high risk times, such as late at night when the highest numbers of drinking drivers are on the road.

They also recommended raising the legal drinking age first to 19 then to 20, and the introduction of probationary licences for young drivers aged 16 to 19 years. These licences might be suspended for any serious violation.

CFADD wants reduced BAC level for drivers

THE EFFECT of alcohol on traffic safety was a high priority on the CFADD's own agenda.

In issuing its series of resolutions at the conclusion of the conference, the foundation petitioned the federal government to reduce the legal BAC-driving threshold to 0.04%, and to provide for roadside compulsory testing without the need for grounds for believing the driver had been drinking or was impaired.

The CFADD further petitioned provincial governments to increase the drinking age to 20 years in provinces that have grade 13, and to 19 years in provinces that do not have grade 13. The intent of this resolution was to sweep alcohol out of the high schools.

In other resolutions the CFADD:

- petitioned provincial governments to adopt a policy of taxation that would link the price of beverage alcohol to average disposable income;
- pledged itself to encourage a ban on the promotion of tobacco and to break down the link with "good life" advertising as well as to curb tobacco promotion via sports events;
- supported the federal government's action in seeking to curb alcohol promotion on the basis of lifestyle.
- and urged the federal government to initiate training programs for managers and supervisors in the federal public service in order to make their alcoholism programs effective.

New officers for Canadian foundation

THE CANADIAN Foundation on Alcohol and Drug Dependencies has elected a new president and four new members to its board of directors.

Jim Edwards

Jim Edwards, Edmonton regional director with the Alberta Alcoholism and Drug Abuse Commission, was elected president during the CFADD's annual conference, INFORMACTION.

Mr Edwards, 44, joined AADAC in 1965, working in various capacities as a treatment counsellor, group therapist, and supervisor of an out patient clinic. For 14 months he was also director of the Henwood Rehabilitation Centre, an AADAC program.

For the last eight years he has administered the Edmonton Regional office of AADAC.

New members of the CFADD board of directors are:

- Arthur Young, director of the New Brunswick Alcoholism program;
- Fernard Parenteau, a research and planning officer with the Quebec department of social affairs;
- Garth Toombs, director of regional programs with the Addiction Research Foundation of Ontario, and
- Lorne Phillips, director of prevention, education, and staff development for the Alcoholism Foundation of Manitoba.

Milan Korcok, Gary Seidler and Karin Sobota report from the conference held June 20 - 25 in Toronto.

INFORMACTION 1976 INFORMACTION

Camera break

Conference hosts took a breather to pose with guests speakers. From left to right: David Archibald, executive director of the Addiction Research Foundation; Pauline McGibbon, Lieutenant-Governor of Ontario; Henry Schankula, director of Administration, ARF; Eugene LeBlanc, conference chairman and director of the Research Branch, Ontario Ministry of Health, and; Richard Anthony, past president of the Canadian Foundation on Alcohol and Drug Dependencies.

Feminist counselling needed

WOMEN'S EVOLVING role in society, coupled with doctors', therapists', and researchers' antiquated perceptions of women as happiest in domestic situations, are key reasons for the necessity of replacing obsolete treatment methods for female alcoholics.

Doreen Birchmore, head of the day clinic at The Donwood Institute, a Toronto-based treatment centre for alcoholics, told a session on women and alcohol, that an ideal treatment situation for a female alcoholic would involve feminist counselling and group counselling with other women.

Ms Birchmore said current treatment methods employed by therapists for female problem drinkers are essentially those developed for the male alcoholic population, and do not take into account the needs of women or explore their complex reasons for turning to alcohol.

"We can't blame women's chemical dependency entirely on their secondary role in society. But I do feel that boredom, depression, and feelings of powerlessness suffered by women as a result of the frustrations felt in their roles, or the conflicts that occur because of these roles, certainly could play a part in their escape to addiction."

Because many people involved in treating female alcoholics have made the assumption that women are biologically in tune to their secondary roles (based on ground-rules established by Freud and others), traditional therapy may hurt an alcoholic woman more than it helps, she said.

Backing up traditional treatments is research about the female alcoholic that Ms Birchmore called scarce, contradictory, and variable, depending upon the sex of the individual researcher.

"Nor do these studies often consider the role of women, or the societal influences upon women," she added. "Often tests and measurements of femininity and masculinity are based on stereotyped concepts of the passive female and the strong, aggressive male."

In addition to research samples being small, many of those that do exist have been taken from prisons and psychiatric hospitals since this is where women with alcohol problems are most accessible to researchers, Ms Birchmore explained.

In 1974, The Donwood Institute began to examine characteristics of women alcoholics, comparing 100 female drinkers with 100 non-alcoholic women. The groups were matched for marital status and work status and there were no differences in age or education.

Although both groups expressed similar attitudes to the world and women's roles in general, the alcoholics expressed a "tremendous sense of personal inadequacy".

"Because of the very low self-image that women alcoholics have generally, the focus for their treatment must be in the direction of improved confidence, self-worth, and assertion," she concluded.

Alcoholism

Newfoundland

GRAVE EVIDENCE of soaring alcohol use in Newfoundland has not had the anticipated result of spurring establishment of that province's first full-time detoxification unit or other badly needed services.

According to co-authors Richard Boczkowski and Patrick Tribbe of Newfoundland's department of health, the information contained in a report review
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BEHAVIORAL THERAPY in the field of drug abuse has suffered from lack of discipline and accountability, Charles Aharan, director of the Victoria (British Columbia) Life Enrichment Society told the conference.

"Most programs are financed by government, and for the most part program operators are not required to produce results. Money has been given to people to go and do something — anything — with no requirement that they demonstrate effectiveness," said Dr Aharan.

"If we could survey the field from some Olympian height I am sure we would observe myriads of busy people. Some would be feverish and evangelical, some cynical, some cool and professional, some battered and worn, but all would be busy doing treatment.

"If we take a closer look and ask what are they doing precisely . . . we would observe that some are saying 'don't take that drug — take this drug'. Some are saying 'don't take that drug', some are lecturing at, some are praying over, others are threatening and yelling, some are shaving people's heads, and some are meeting with groups and yelling 'hey man' a lot.

"And it is all treatment, behavioral therapy for the chemically dependent."

Despite the fact nearly 90% of all funds available for treatment of the chemically dependent are spent in support of behavioral therapy, "we are unable to say much more about treatment than was said nearly 200 years ago," said Dr Aharan.

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Children of at risk but

THE PLIGHT of the children of alcoholics is receiving increasing attention in scientific literature. But there is much room for improvement.

In a critical review of the literature over a 25-year period, Dr N. el Guebaly, psychiatrist-in-charge, addiction services, Royal Ottawa Hospital, noted a variety of findings and contradictions in studies concerned with the children of alcoholics.

Dr el Guebaly said the offspring of alcoholics appear to be at increased risk for the serious psychosocial illnesses of adulthood.

"Their at risk status needs to be compared to that of the offspring of parents with other types of serious psychiatric illness. Such information is needed for planners and workers in the child mental health field," he said.

Dr el Guebaly said it is unfortunate that only lip service has been paid to the treatment needs of children. Since 1957, he noted, Alateen remains through its literature and meetings the main therapeutic resource available to the children of alcoholics.

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Attitudes, behavior shift

Students sign abstinence pledge

CONTRACTED ABSTINENCE may be a useful device in alcohol education, according to preliminary results of an attitude and behavior study involving students at the University of Nebraska-Lincoln.

The term 'contracted abstinence' was used to summarize a procedure whereby a student signed a contract (pledge) not to drink for a period of two weeks in order to view drinking from an abstinence perspective.

It appears the impact of the abstinence experience on attitudes toward both drinking and tolerance of non-drinkers was favorable, i.e. moved in the direction of more responsible attitudes toward drinking and greater tolerance of those who chose to abstain, reported Steven B. Blum and P. Clayton Rivers, both of the university's department of psychology.

Stephen Blum

The study involved 16 male and eight female college students enrolled in a five-week summer session psychology class entitled The Psychological Aspects of Alcoholism. The students ranged in age from 20 to 30 years.

They reported their drinking behavior for 10 days on Sobell and Sobell's inventory of drinking behaviors. They also completed a questionnaire measuring their attitudes toward alcohol use and abuse.

During the abstinence period, students kept diaries describing their reaction to drinking at parties while they themselves abstained.

Following the abstinence period, the students continued filling out daily drinking records for another 10 days.

The five-week course met daily and lectures and discussions were provided about the psychological aspects of alcoholism.

The authors said the most startling observation of the study involved the large discrepancy between the amounts students predicted they would drink as compared to the actual amount they consumed.

While the post-abstinence data revealed lower actual drinking as well as lowered predicted drinking, this large discrepancy remained fairly constant.

As a whole, the class predicted they would drink 16.10 drinks per day, while actually consuming, on the average, 43.30 drinks per day during the pre-test. The post-test results dropped the prediction to 9.36 drinks while actual consumption dropped to 30.55.

These results, said the authors, suggest that a high degree of impulsive drinking could occur in college populations.

Students increased their knowledge of alcohol and its effects and while this finding is not directly related to the abstinence research, the authors stress that increased knowledge is an important educational goal, quite apart from modification of attitudes and behavior change.

The students found a high degree of peer pressure to drink. Eleven requested copies of the abstinence contract to carry with them at parties in order to have a justification to refuse drinking.

However, results of the students' ratings of the class experience indicate the abstinence experience was rated relatively highly.

The implication of these findings, said the authors, if they bear up to further statistical analysis, is that contracted abstinence alone can have an impact on attitudes and drinking behavior.

They said the strategies employed in the study are potentially useful in reaching the three basic goals of alcohol education — increased knowledge, promotion of positive attitudes, and positive behavioral change.

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Provincial Program Recommendations in the Province of Newfoundland, was paid for by the federal Non-Medical Use of Drugs Directorate, and delivered to the Newfoundland government by that province's Alcohol and Drug Directorate in December, 1975. Segments of it were presented at the conference.

In a subsequent report by the same authors, however, the earlier optimism about the establishment of treatment services had faded.

The second report, also supported by Non-Mudd, dealt with specific alcohol problems in Labrador — the mainland territory of the island province.

In it, the authors referred to their first study: "The study was never formally acknowledged by government, and in the new budget no money was allocated for any of the recommended programs. Labrador (with a large native population) will (also) receive no such programs."

It went on to say: "In no time in history did the provincial government spend more than 1% of its revenue from the sale of alcohol alone on alcohol abuse prevention or treatment programs."

From the first study:

In 1966, Newfoundland recorded the lowest per capita alcohol consumption in Canada. By 1973, it had experienced an 87.8% increase in per capita consumption (the greatest increase in that time period in the country), and achieved the dubious distinction of having the 6th lowest per capita consumption of all provinces and territories. Only the Yukon and the Northwest Territories had a higher per capita consumption of beer than Newfoundland, the favored drink in the province.

Based on sales of absolute alcohol, there were an estimated 9,783 alcoholics in 1973, a 97% increase in the estimated number of alcoholics since 1970. Estimates indicate there are 12,738 alcoholics in the province today.

Data collected between 1970 and 1973 from provincial hospital records show:

- a 129% increase in frequency of primary diagnosis of cirrhosis of the liver requiring hospitalization;
- a 102% increase in the frequency of primary diagnosis of behavioral problems related to alcohol;
- a 237% increase in alcohol-related psychiatric problems;
- a 150% increase in alcohol poisoning requiring hospitalization along with a 1050% increase in the number of day beds used; and
- a 297% increase in reported hospital costs for alcohol-related disorders (primary diagnosis only).

The costs of drinking and driving between 1970 and 1975 also soared: a 238% increase in the number of impaired drivers charged; a 100% increase in the rate of fatal car accidents involving alcohol; a 41% increase in the rate of non-fatal car accidents involving alcohol; and an 85% increase in the rate of alcohol-involved accidents resulting in property damage of over $200, for a total increase of 71% for all motor vehicle crashes involving alcohol consumption in the province.

Medical facilities for treatment of alcoholics are now limited to general hospitals with only two alcohol programs operating, both out of the capital city of St. John's. A few patients are referred to centres outside the province and, said the first report, many alcoholics are treated "on the hoof" through outpatient departments or physicians' offices. Most often, however, the patient is diagnosed symptomatically and presumably treatment is aimed primarily at the symptom.

Although the establishment of a detoxification centre and "one or two" professionally staffed treatment units, along with further epidemiological research, was recommended in the report, lack of action on the part of the provincial government spawned this observation in the later Labrador study:

"It would seem that there is a moral issue involved when the government encourages the sale of alcohol, (it is the leading revenue collector of all the provincial government's enterprises), yet in turn provides no treatment services for those unfortunates who become addicted. The onus of providing help falls upon the already overcrowded hospital facility . . ."

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whether or not it is worth doing.

"The absence of a solid body of knowledge plus the absence of any external requirement to account for one's activities makes our field a lush one for those who believe they have the truth by the tail."

He said: "This field is full of prophets, evangelists, and other believers who, since they 'know the truth' can see little reason for either asking or facing rigorous questions."

He attributed part of this lack of accountability to governments' lack of real interest in the field of chemical dependence.

Though governments provide most of the funding for drug abuse treatment, they do so as a "token response" and are motivated more by political than health care objectives, said Dr Aharan.

Government's attitude appears to be that since not very much money is involved anyway, and since the political value of such activity is "to be seen", then who cares about its effectiveness?

This slackness has resulted in unnecessary and costly duplication of services, he said.

He believes behavioral therapy has to be based on the conviction that given the right set of conditions, the individual can and will make different choices. Thus a treatment or change program should involve a "systematic attempt" to influence the individual to make different choices.

A person must be influenced by those things which he values, he said. Consequently, it is critical that the major values of any change program be explicitly stated and obvious to all.

Failure to apply this kind of evaluation to one's own work, or even to question the reasons for one's activities will constantly work to the detriment of the field of behavioral therapy, said Dr Aharan.

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lems faced by children of alcoholic parents;

- We should encourage family involvement in counselling the alcoholic parents. Even though family therapy is coming into wider use in alcoholism counselling settings, very often children are not included;
- We should advocate inclusion of child treatment experts on the alcoholism counselling team;
- Treatment should involve the entire family, and the goal of treatment should be broader than the achievement of sobriety by the alcoholic parent.

"Resources are limited and, traditionally, the primary focus in the alcoholism field has been on treating alcoholic people.

"But efforts directed at early intervention in the lives of children of alcoholic parents are one of the most cost effective ways we can spend alcoholism energies and money," Ms Hindman said.

"Such efforts deserve a place high on the priority list in programming and research."

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ingly aware that other methods, especially drug-free treatment approaches, were available;

- time-constraints and negative experiences with methadone patients reduced the enthusiasm of some practitioners.

Other factors which contributed to reduced availability of methadone included reorganization on the part of some clinics which reduced patient intake; a number of clinics had ceased operation; several programs had increased their requirements for entrance and retention; some clinics changed to detoxification as the treatment of choice.

At the same time, the committee found the narcotic-using population was changing in ways that reduced the numbers seeking treatment.

The number of known new users declined between 1973 and 1974. This decline, if it reflected a decrease in the number of new users "on the street", may have accounted in part for reduced clinic intake, as new young users are thought to be less likely to seek treatment than long-term users, says the committee's interim report.

The survey showed a new kind of narcotic user had appeared, one who seldom established the traditional "junkie" lifestyle, and thus was not under much pressure to seek treatment.

Also, narcotics users were thought to be less seriously dependent than previously. Reasons for this included a trend toward multiple drug use, including use of cocaine, tranquillizers, barbiturates, and alcohol, both for the pleasurable effects of these drugs and for self-treatment, particularly when heroin was unavailable.

The committee also found attitudes of narcotic dependent people toward the pharmacological properties of methadone changed, reducing their interest in the drug as a treatment approach.

Some felt orally administered methadone was not an adequate substitute for intravenous injection of heroin. Others believed methadone was just as addictive as heroin and withdrawal more difficult and prolonged.

Some methadone patients experienced unpleasant side effects they felt were worse than those associated with heroin use.

The committee also concluded that attitudes of narcotic dependent people towards some treatment centres, and more generally toward the typical methadone maintenance lifestyle, were becoming negative.

The reasons given for this negativism included: —

- the need for daily visits to obtain methadone restricted activities, including work and recreation;
- patients reported that some clinics were inflexible and insensitive;
- the lifestyle associated with methadone maintenance was becoming a bore for many dependent people; and
- patients missed the excitement and peer contact of the street lifestyle, while feeling alienated in the clinics.

Emphasis changes in TCs

BECAUSE OF the pervasive sense of inadequacy and self-contempt that many addicts harbor within themselves, a principal element in every component of a milieu therapy program should be to enhance the resident's sense of self-worth.

This should be parallelled, said the director of a Canadian therapeutic community, with a program of equipping the addict with real social and vocational skills, along with enhancing his sense of responsibility, self-sufficiency, and independence.

"Without doubt, if the resident can complete the program with a sense of competency he will have achieved perhaps the principal ingredient of human effectiveness," John Devlin, of Montreal's Portage Program told the conference.

"The world will have begun to respond to him in a positive way," John Devlin of Montreal's Portage Program told the conference.

Mr Devlin noted that as the conception of the addict has evolved through the decades, so has the nature of the clientele of the therapeutic community changed.

While in the 1960s, lying, manipulative, psychopathic opiate addicts filled the rosters of TCs, most clients in the 1970s have become polydrug users and, in general, reflect neither the problems nor the competencies of the earlier opiate addict.

"Our finding at Portage indicate these individuals now have as their pervasive symptoms, problems in self-concept and adaptation," Mr Devlin said.

The addiction specialist and the applied social scientist are struck by a number of salient and recurrent patterns in the delinquent population they work with, according to Mr Devlin.

Among the most important, in terms of the strategies that must be devised to promote rehabilitation, are:

- The presence of a negative self-concept and feelings of worthlessness and inadequacy;
- A personal history of social rejection and failure-proneness in interpersonal relations.

Contrary to the view that pervades Canada's LeDain Commission Report on Treatment (1972), Mr Devlin does not envision a medical solution to the problem of drug addiction.

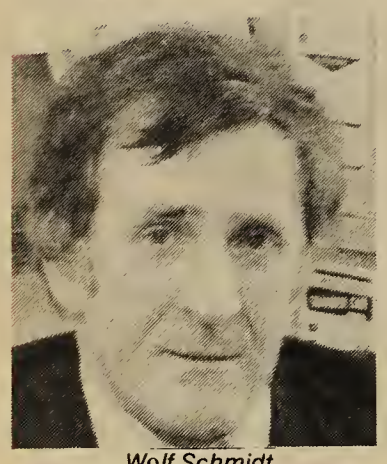
John Devlin

INFORMACTION 1976

A grim statistical forecast

Cirrhosis deaths are spiralling in Canada

CIRRHOSIS OF the liver has become the fastest growing killer of Canadians over age 25, a leading epidemiologist told the conference.



Wolf Schmidt

Deaths caused by cirrhosis linked to alcohol abuse, more than doubled over the last 20 years in Canada and will double again by 1985 unless governments institute much stronger controls, said Wolfgang Schmidt, associate research director, social studies, Addiction Research Foundation of Ontario.

In a plenary presentation which set the tone for the conference, Dr Schmidt painted a grim picture with a barrage of statistical data which reflected Canada's soaring alcoholism rates.

Based on past trends, Dr Schmidt predicted that Canadian adults would drink 3.95 gallons of alcohol a year by 1985, a 73% increase over the 1972 rate, unless governments tighten alcohol control laws.

Using liver cirrhosis as the longest established and most reliable yardstick, he said the upward swing in related alcohol deaths is particularly striking among middle-aged men.

In 1945, among men aged 40-49, there was one cirrhosis death for every 115 deaths from all causes; in 1972, one out of 18 deaths in this age group was attributable to cirrhosis.

Expressed another way, 5.6% of total mortalities in this age group were linked to cirrhosis.

"This trend becomes particularly important if the impact of alcoholism is judged from the loss of time span or the reduction of working life it causes," Dr Schmidt said.

He linked the rate of overall alcohol consumption to heavy drinking patterns and pointed out a moderate drinker can soon become a heavy drinker as drinking becomes more and more socially acceptable.

Blaming increasing alcohol consumption on this sort of social contagion, Dr Schmidt said "a rising consumption affects the drinking habits of every consumer with the semblance of a spreading wave".

He said the more a person drinks, the more he offers his friends. His friends, in turn, feel obligated to offer him more alcohol, and so it goes on.

Dr Schmidt said governments have found it expedient to accept the theory of integration of alcohol into our daily lives because they (governments) thought public sentiment favored more liberal alcohol regulations.

But, he believes, governments should act to reduce alcohol consumption by implementing a taxation policy that increases proportionately to disposable income.

Dr Schmidt said the old argument that the way to teach people how to handle alcohol wisely is to introduce the drug to them at an early age and make it an integral part of everyday living has proven to be erroneous.

An advocate of government education programs to increase public awareness of the personal hazards of heavy alcohol consumption, Dr Schmidt pointed to recommendations made by his organization to the Ontario government as a means to curbing alcoholism and deaths by cirrhosis.

These recommendations are: —

- a taxation policy which maintains a reasonably constant relationship between the price of alcohol and levels of disposable income (income after taxes) in the province;
- a moratorium on further relaxation of alcohol control measures and the adoption of a health-oriented policy with respect to such measures. The relevant question would become: are the proposed changes likely to contribute to higher consumption levels and therefore an increase in health costs?
- an education program designed to increase public awareness of the personal hazards of heavy alcohol consumption, the economic and other consequences for society of high consumption levels, and the potential public health benefits of appropriate control measures.

Dr Schmidt pointed out as little as three to four ounces of whiskey (or its equivalent) for women and between five and six ounces for men may measurably increase the chance of serious illness.

United Church vehement about alcohol controls

RIGOROUS MEASURES to stop mass alcohol advertising from enticing more and more Canadians to drink more and more have been strongly recommended by Rev Robert Lindsey, associate secretary, division of mission of the United Church of Canada.

He told a session at the conference that Canada should seriously consider the possibility of nationalizing the alcohol industry as a way to curb growth of liquor consumption.

"Until brakes are applied to the profitability of brewing and distilling through expanded sales and advertising, the best laid preventions will be as smoke up the chimney," Mr Lindsey said.

The General Council of the United Church of Canada, he added, had on three separate occasions since 1944, called for the nationalization of the industry.

"The alcohol question is not *just* a personal question it is definitely not *just* a business question, it *is* a public question," he said.

Third World won't stand by forever: Archibald

(from page 1)

A major part of the problem society faces in defending itself against drug abuse is that the pattern of such use so swiftly changes and is so subject to fads and fashions.

"It is a moving target," said Mr Archibald.

In Hong Kong, long a stronghold of opium smoking, heroin use is increasing rapidly and to this is being added use of barbiturates and some of the newer psychotropics, he said.

In Burma, where 100,000 known opium addicts eat or smoke one third of the 300 metric tons of opium produced illicitly each year, intravenous heroin use by middle class youths has been increasing.

In Pakistan, another major opium-producing country, recent surveys show that 65% to 75% of students have reported experimenting with various psychotropic drugs, including barbiturates, amphetamines, and various hallucinogens.

In Thailand, use of cheap, high-quality heroin is a major drug problem. Some of this heroin is up to 80% and 90% pure, said Mr Archibald. Treatment services report that the average age of users is dropping and many 16-year-olds are presenting for treatment.

In Europe, although alcohol remains the major drug of abuse, sale of heroin via the Amsterdam connection has been increasing significantly.

In the Netherlands, drug law enforcement has become such a high priority that it has begun to distress a number of neighbouring countries, he said.

Representatives of the Federal Republic of Germany have noted an increase of heroin smuggling over the German-Dutch border, and they have also found that this increase in heroin use coincides with an increase in alcohol abuse among young people.

Responding to such divergent trends is a difficult task as it involves so many facets of life and community activities, said Mr Archibald.

Among the hill people of Thailand, for example, opium is the only readily available medicine for a whole range of ills that results from a particularly hard life style.

Suppressing availability of opium for these people without providing adequate health and social care facilities would be a negative response, he said.

"Until such time as minimum basic health services are provided for rural populations in opium-producing areas, there is little chance of overcoming the problem of opium-dependence among these people.

"The development of primary health care services in the Third World should be one of the highest priorities of the World Health Organization.

"In spite of considerable progress, however, even the barest minimum of health care has not yet reached the Golden Triangle area of Thailand, Burma, Laos. Nor has it reached the areas of Afghanistan, Pakistan, Nepal, and many, many countries of Africa."

Mr Archibald said that in the past few years the notion of subsidizing Thailand's farmers to switch from poppy cultivation to other pursuits has been receiving much attention. But crop substitution is a complex activity that must involve the entire community, he said.

Roads have to be built to the villages so new crops may be transported to market, new and modern concepts of agriculture must be tested, and the population has to be taught new farming methods. Language differences between the hill tribes also have to be overcome.

Integrating all of these facets demands the wholehearted involvement of the people there, said Mr Archibald.

"It is unrealistic for UN agencies to draft programs and objectives in Geneva or New York. They must be responsive to the needs of participating countries and work in partnership with them."

Opium production in Southeast Asia is not a factor isolated to this part of the world, said Mr Archibald. To the hill tribe, opium is a cash crop, one that finds its ultimate payoff in Vancouver, and Toronto, and Detroit, etc. In opium production the big money is not made by the farmer, but by the chain of entrepreneurs between the producer and the addict.

"We cannot end up with a net social gain if, in the course of legally enforcing the suppression of opium, you deprive the rural farmer of his only source of livelihood."

Mr Archibald warned the conference that the Third World was not going to stand by forever and see such priorities as economic stability and the provision of health services denied.

"It is in our own very selfish interest to be concerned. The people of the Third World are not going to stand idly by watching their children die from disease or hunger while we, with all of our luxury, go on endless strikes for even more and more goodies of the country.

"The Third World is serving notice now, in the United Nations Assembly, in the WHO assembly, in the UN Habitat conference, and in the revolutions occurring in so many countries."

David Archibald
"The development of primary health care services in the Third World Countries should be one of the highest priorities of the World Health Organization."

Quebec car crash fatalities

75% of drivers had been drinking

MONTREAL — More than half of 284 drivers killed in car accidents in the Montreal and Quebec City areas in 1975, were drunk or at least under the influence of alcohol.

Of the 284, only 103 were sober.

Although autopsies were performed in all of these cases, they are not necessarily done in all car crash deaths in the province.

Blood sample investigations after autopsy, showed that almost half (49.5%) of these 284 drivers were intoxicated, i.e., the blood-alcohol concentration was above the legal limit of 0.08%. Another 14.5% were under that limit but had been drinking.

The statistics on the dead drivers were compiled by the Quebec Medico-Legal Laboratory, in Montreal. Jean-Paul Valcourt heads the lab and is also president of the Canadian Society of Forensic Sciences.

"Some of those whose blood levels were over the 0.08 level, were *very much* over," Dr Valcourt told **The Journal**.

The reckoning showed that Quebec City, with its smaller population, and the surrounding area, has the more serious problem. Blood samples from 115 dead drivers showed 54% were over the legal limit, while 10% were under the influence of alcohol. Only 41 of the 115 drivers were sober.

In the Montreal area, of 169 dead drivers autopsied, 46% would legally have been considered intoxicated. — 17.1% of the others had a lower level of blood alcohol. Here, 62 drivers were sober.

Although useful, such statistics may be somewhat misleading as they only deal with autopsies, Dr Valcourt pointed out.

"In my judgement, I would say that in the last four to five years, 35% of drivers dying at the wheel or immediately after the accident were intoxicated. Another 45% of the total had some level of alcohol in the bloodstream."

In the City of Montreal, he explained, an autopsy is almost mandatory in the case of a car-accident death. In the environs of Montreal, however, there are many coroners and the lab took samples from drivers killed within a 100-mile radius. These coroners do not necessarily ask for an autopsy. In Quebec City, autopsies are the generally performed but they are not necessarily done in the surrounding area.

Dr Valcourt believes use of seatbelts means a reduction in deaths. (The use of seatbelts is not obligatory in Quebec.)

"The experience that Ontario is having since seatbelt legislation was brought in bears me out.

"One aspect that can't be computed is the sum that Ontario residents will save in hospital bills. Seatbelts not only prevent death, but serious injury in many cases."

More Letters...

cern, because concern activates prevention, and that is certainly not visible yet!

Third, and my biggest beef; as a member of the Regional Advisory Committee for Ontario of the Non Medical use of Drugs Directorate, I was offended and wish to protest against your glib use of derogatory statements like "three years of relative nothingness" and "with respect to the alcohol mandate it developed three years ago, it has been batting zero".

It might have been wiser for the editor of "our" journal to get the correct information before writing articles of questionable value with regard to co-operation. If you would like to see "the facts of life", I can provide you with some figures, but forgive me that I do not have them all on my finger tips here at the Sault. However, one phone call to 80 Scollard Street — Telephone 966-6483 — will give you all the information you need to erase your lack of insight into the operation of Ontario Office of the Directorate which, with its limited amount of funds, tries very conscientiously to respond to cries for help where people are suffering.

For the year 1974-75, Non-Mud spent $1,944,448, or 34% of its total budget on alcohol programs. Breakdown — for research projects $270,824; for innovative services $1,624,457; and for information services $49,167. In 1975-76, the total amount was $2,542,585 or 54% of its total budget. Again broken down in the same categories — research projects $734,485; innovative services $1,577,100; and information services $231,000.

You wrote "insight is always a blessing". I hope that this will become true for you.

Anthony van den Bosch, MSW
Centre Director
Northeastern Ontario Region
Addiction Research Foundation of Ontario
Sault Ste Marie, Ontario

Healthy

Sir:

Today, in receiving my monthly edition of **The Journal** (April) and taking special notice of the article "I Have A Healthy Body", I was overjoyed by the fact that Kerry Hart Stowell, "is putting into practice that the prevention of juvenile drug abuse has to be started early in life".

To you, Kerry Stowell, the feeling is mutual. Much energy, money, programs, etc. are on the wayside because we have started too late with "our interpretation" of prevention, and needless to say, many have paid the price for our lack of knowledge in the field we declare as ours.

If more "professionals" would take just one day and spend that time watching *children* in a school playground with their spontaneity, honesty, being REAL — how much *we* could learn.

Ronald C. Sauers
Coordinator
Chemical Dependency Unit
Dakota County Mental Health Center
South St. Paul, Minnesota

Martha

Sir:

I read, with interest, Anne MacLennan's article on Martha Davis' activities at the recent National Drug Conference in New York City (**The Journal**, May .) While I share Ms Davis' frustrations with bureaucracy, I very strongly disagree with the methods I witnessed at the Americana. Shouting down speakers and telling members of the audience to "Get out if you don't want to get hurt", is inappropriate behavior for the national conference of a group of workers that is struggling for professional legitimacy.

Drug abuse and drug abuse workers have been treated by "the establishment" as semi-legitimate precisely because of our anti-professional, socially demanding factions that clamor for recognition. Rather than call attention to the problems that cause drug abuse, the Harlem Drug Fighters have focused attention on the problems of dealing with those involved in the field.

In my opinion, the drug abuse field suffered immensely from the actions of those at the National Conference who would not let others speak. Their continued association with our field prolongs its struggle to attain respectability and makes serious discussion and work impossible.

Lindsay Wilson
Caseload Supervisor
Operation PAR, Inc.
Comprehensive Drug Abuse Program
St Petersburg, Florida

Minnesota law

Sir:

My heartfelt congratulations to Saskatchewan for the intelligence and courage they have shown in raising their drinking age after lowering it to 18, as you reported in June.

I must, however, point out that contrary to your report, it is not the first jurisdiction in North America to do this. On March 19 of this year, the governor of Minnesota signed the law which raises the drinking age here, also from 18 to 19. Like the Saskatchewan law, it is effective September 1. A number of people including members of our International Organization of Good Templars worked hard to see this law through the legislature, and we know that such an accomplishment is not easy.

Donald J. Kleven
Director of Legislative and Educational Activity,
Northwest Council,
International Organization of Good Templars
Minneapolis, Minn. 55410

From page 4

Sir:

I presume you will receive many other letters pointing out that the state of Minnesota was the first jurisdiction in North America to reverse the trend in lowering the legal drinking age. Governor Wendell Anderson of Minnesota signed the bill raising the legal drinking age in Minnesota from 18 to 19, effective September 1, 1976, in early April of this year.

I mention this only in the interest of strict reporting accuracy. I rejoice in the fact that there are now at least two jurisdictions that have taken this action. Hopefully, others will follow.

Thank you for the continued excellent and informative reporting provided by **The Journal**.

Harry W. Beardsley
Public Relations Manager
Preferred Risk Mutual Insurance Co.
West Des Moines, Iowa 50265

The Journal welcomes Letters to the Editor. Letters may be sent to The Journal, 33 Russell St., Toronto, Ont., M5S 2S1.

New deep-brown heroin fad is worrying UK specialists

LONDON — A crude, deep-brown heroin product originating from the wealthy Iranian student community and apparently intended for private consumption rather than illicit trade is worrying British specialists.

"Injection could be very dangerous," one comments, "as it appears to have been refined directly from opium rather than morphine base. Consequently, there is bound to be an abundance of garbage and impurities which would do serious damage if it found its way into the bloodstream."

This warning appears in a specialist study published by *Streetlife*, a new fortnightly British journal intended primarily for young people.

Mapping the pattern of illicit heroin consumption in Britain, the journal links "high-level Chinese sources" with trendy businessmen around the music and fashion businesses.

Indigenous British gangs are also moving into this area because profits are so large. This filters through to a middle group who, in turn, connect with a flash, nouveau-riche set where heroin is replacing cocaine as a drug of preference and dealers operate on a three-to-four gram per week level.

"From here on, there are satellite connections in places such as colleges, pubs, squats, and the streets. The most militant and politically involved squats tend to counter heroin use by giving a lot of support to users who want to get off and coming down very hard on dealers."

Heroin and morphine seizures by British customs authorities trebled in 1975, though *Streetlife* emphasizes that it is impossible to determine how much was in transit and how much intended for the British market. But specialists — such as street workers at Release and the Blenheim Project as well as sources close to the Metropolitan Drug Squad — have observed a considerable increase in casual heroin consumption during the past six months.

One Release staff member reports a six-fold increase in his personal heroin-related workload.

Cocaine is apparently losing its attraction while heroin is becoming fashionable among wealthy addicts who can afford the current price of up to £40 (about $75) a gram.

The journal also reports a recent influx of Continental addicts looking for treatment in Britain or unable to handle "the competitive nature of the Amsterdam market. Some are bringing heroin with them to sustain themselves before kicking. Others are bringing their supplies as well."

The journal warns that the stability of Britain's treatment system is threatened by a new prescription policy that has nearly eliminated the availability of licit heroin.

This trend has apparently developed through a "success-oriented" approach of many clinics "which do not want to have their track records impaired by obstreperous addicts whose overall problems seem intractable.

"At one London clinic, there is a single social worker available for almost 250 addicts. Subtle as it may be, the British system is as much concerned with control as it is with help. . . .

"It is by removing the profit from the industry, ceasing to classify drug users as criminals, organizing at street level, establishing after-care projects, publishing honest drug-education material, and providing crisis centres where junkies can get themselves together, that the problem can be overcome.

"Heroin, in itself, is not romantic, decadent or inherently evil. It is merely a commodity that fuels one of the dirtiest commercial transactions known to man."

A crude brown heroin, derived directly from opium has British specialists worried. If injected, the impurities in the substance could do serious damage in the bloodstream, they say.

Young people are drinking anyway

Age limit idea conflicts with fact

WELLINGTON, NZ — The concept of an age limit for drinking is largely unforeseeable and clearly in conflict with what parents in fact allow, New Zealand's National Society on Alcoholism and Drug Dependence has told a Parliamentary committee considering legislation to lower the legal age from 20 to 18.

In principle, said the society's president, Roy H. Johnston, all age restrictions for alcohol probably should be eliminated, but that might be too major a change.

During a transitional period, while other necessary changes are occurring in attitudes to alcohol and abstention, he supported lowering the minimum legal age to 18.

In view of Ontario's experience, however, he strongly suggested that no increases in the variety of alcohol outlets be made until any new legal age has settled in.

The society, a voluntary agency concerned with alcohol and drug abuse, each month sees 1,000 patients with alcohol problems.

Mr Johnston said its day-to-day experience clearly shows that young people have widespread access to alcohol, and drinking begins earlier than many people might expect.

For the majority, drinking is related to the home environment and begins there. Beer is the most favored drink.

Research by the society 10 years ago showed that 78% of young people aged 15-17 drank alcohol quite regularly, only 11% without parents' or guardians' permission.

Mr Johnston said there is an indication that 18-year-olds already conform to the adult pattern of 86% drinking and 14% abstaining.

"There would seem to be therefore no question of lowering the drinking age, since it is already lowered," he added.

W.H.O. calls for more anti-smoking efforts

GENEVA — The United Nations' World Health Organization (WHO) has called on governments to draw up programs for the control and prevention of smoking on a long-term basis and to strengthen health education on the subject.

A resolution approved unanimously by the organization's World Health Assembly in Geneva urged governments to seek the collaboration of health and school authorities, the mass communication media, voluntary organizations, employers' and employees' organizations, and other groups. Health education programs, it said, should take account of "the different needs of various target groups, laying emphasis on the positive aspects of non-smoking, and supporting individuals wishing to stop smoking".

WHO comments that, despite indisputable scientific evidence that tobacco smoking is a major cause of chronic bronchitis, emphysema, and lung cancer, as well as a major risk factor for heart attacks and pregnancy-related disorders, very few countries have so far taken effective steps to combat smoking.

The resolution asked governments to give serious consideration to the legislative measures suggested by a recent WHO expert committee on smoking and its effects on health. These measures included restrictions on advertising, the inclusion of warning notices on cigarette packets, smoking bans in public places, and protection of non-smokers' rights.

In addition, the resolution asked WHO to promote the standardization of definitions, measurement methods, and statistics about smoking behavior, tobacco consumption, and the occurrence of smoking-related morbidity.

Behind the bar

British pub managers want the legal age for working behind a bar dropped to 16 — to help reduce unemployment among young people. The National Association of Licensed House Managers has said it would welcome a training scheme for teenage employees.

Buy your own

The Irish National Council on Alcoholism is encouraging drinkers to stop buying rounds in taverns. A wallet-sized card issued by the council carries the slogan: 'Let's be even better friends and buy our own.' Buying rounds in pubs was banned in Britain during World War I to cut down drinking.

Down Under

More than 10% of Australian doctors are alcoholics and many are drug addicts according to an official of the Sydney Drug Referral Centre.

Moscow Workshop

A Moscow factory has opened the first workshop in the Soviet Union to offer alcoholics a job and therapy at the same time. In the 18 months since the metalworking factory was opened, 150 people have answered the factory's ads for jobs. So far, 45 of the alcoholics employed there have stopped drinking, 78 are still under observation and 27 have returned to the bottle.

French ad ban

The French government has agreed to a ban on all tobacco advertising except in the press. The ban will apply to broadcasts, cinemas, places of entertainment, and neon signs, as well as promotional material that carries a tobacco brand name.

More aid for Turkish opium crops

GENEVA — Turkey is about to receive a further $2.6m international aid for the orderly development of its opium poppy industry.

The United Nations Fund for Drug Abuse Control (UNFDAC) has just signed two agreements with Turkey, both to help control opium poppy growing.

One of them provides for $1.9m aid for the installation of a sophisticated photographic system to identify and locate illicit poppy cultivation. The second agreement is for $700,000 to finance the expansion of a telecommunications system in two of the seven provinces where Turkey recently resumed opium poppy cultivation after a short-lived, total ban.

Both agreements were signed by UNFDAC executive director Jacobus de Beus and Turkish Ambassador Coskun Kirca.

The Turkish diplomat expressed satisfaction over the effectiveness of a series of strict controls imposed by his government on opium poppy production intended to keep the industry out of the hands of drug smugglers. A UN technical mission is about to go to Ankara for discussions on implementing the international assistance program first provided by UNFDAC last year, just a year after Turkey lifted the production ban on opium.

Specialists here consider that Turkey is likely to receive substantial further international assistance for the establishment of modern facilities to store and process opium.

British should benefit from Canadian experience

LONDON — Britain should seriously consider the ramifications of any proposal to lower the drinking age in light of the disastrous results such action has had in countries like Canada.

John Havard, doctor, lawyer, and consultant to the World Health Organization and the Council of Europe on medical aspects of road accidents, said teenage drivers who drink present "probably the most serious public health problem" facing authorities in Britain today.

Since introduction of the 1967 breathalyzer law, the proportion of teenage drivers found with blood alcohol concentrations over the legal limit of 0.08% has doubled.

The Blennerhassett Committee

UK proposals expected to be controversial

LONDON — More random breath tests and bans on convicted problem drinkers regaining a driving licence until proving in court their habits no longer present a danger on the road, have been proposed following a two-year official study of Britain's drinking and driving law.

A general tightening of the 1967 legislation that would erase legal nitpicking and close loopholes that have allowed patently guilty drivers to escape, is called for by the government-appointed committee under lawyer Frank Blennerhassett.

Contrary to many expectations the report says that the present blood alcohol limit of 0.08% should remain. It had been thought the committee might recommend a 0.05% limit.

Canadian and American experience with breathalyzers led the committee to recommend breath tests as the normal method of determining a driver's blood alcohol level. The present blood or urine test, following an Alcotest screening, could be discontinued, although a blood test could be a fallback if the breathalyzer is over the limit.

Lifting the restrictions on the power of the police to conduct breath tests would not lead to completely random testing, the report says. But it adds:

"To remedy the defects in the law and to provide the basis for appropriate and effective enforcement of it, the present limitations on the power to stop and test drivers have to be removed. We regard this as an essential and integral part of our proposals."

It points out that the present legal limitations encourage people to take a chance on the assumption that they are unlikely to be tested if they avoid an accident or commit a moving traffic offence. It would be a salutary effect if a driver knew powers of police to stop him are no longer limited.

The report declares: "We do not believe that an unqualified discretion to require a breath test would be an unacceptable invasion of personal freedom. Motor vehicles cause so many casualties that those who drive them should be, and in fact are, subject to restraints and restrictions.....

"We believe that there is a need for police officers to have wide discretion to test drivers for alcohol, and that the great majority of motorists, far from finding this unacceptable, would be comforted to know that active steps are being taken to detect drinking drivers."

As for what the report calls high risk offenders, it points out that there are an estimated 300,000 to 400,000 alcoholics in England and Wales alone. The number per population is even higher in Scotland which has the highest rate of alcoholism in Britain. And they present a special danger on the roads as they cannot control their drinking behavior.

The report says that by general agreement a person who is convicted twice within 10 years for drinking and driving qualifies for the high risk category.

The same applies to drivers convicted with a blood alcohol level so high that most people could not reach it without nausea and other unpleasant symptoms.

Together they add up to some 15,000 cases a year.

Evidence to the committee showed that blood alcohol levels over 0.15% are found in two-third of second offenders but in only half of first offenders.

Thus "a high risk criterion based on a specified high blood alcohol level would identify many who are likely to be convicted again if nothing further is done to influence their conduct".

The committee recommends that those with a blood alcohol level of 0.20%, together with second offenders, should be classified as high risk and special procedures be taken before they are again issued with a driving licence.

The proposals are highly controversial and likely to generate much heated debate before they are incorporated into a new Road Safety Bill.

But the most medically sought after measure of all — a reduction in the legal blood alcohol limit from the present 0.08% to 0.05% is not recommended by the 12-member committee.

Undoubtedly, the proposal that police should have power to make random checks on motorists will arouse most opposition. At the moment a police officer may only demand that a motorist undergo testing if he is involved in a traffic accident or has committed a traffic offence while his vehicle is actually moving.

The medical lobby want stronger police powers because they point out that the great benefits of the 1967 Road Safety Act — when breath testing was introduced — have now almost been eroded (the accident rate having risen to a point approaching the pre-1967 Act level).

It is calculated that the breath test has saved at least 5,000 lives on British roads.

From the police point of view, the most welcome changes in the law would be the introduction of better breath-testing equipment and the removal of loopholes through which many motorists avoid conviction under the present Act.

The favoured breath-testing device is one employing fluid cell meters (known as the Alcometer). Initially it would be used as a screening test to help the police officer decide if the motorist should be "invited" to submit himself for a blood test. Later, however, once the accuracy of the machine was beyond question, it might be used to provide actual evidence of a driver's incapacity to drive actual evidence of a driver's incapacity to drive — providing he accepts the verdict.

This — as well as other recommendations — would considerably reduce the loopholes which some motorists have used to avoid conviction under the present Act.

Hong Kong addicts spend $100m a year

LONDON — The British Crown Colony of Hong Kong spends more on illicit imports of narcotics than on maintaining its police force, prison department, and department of commerce.

E.I. Lee, the narcotics commissioner, told an international customs conference there that, hit by inflation, local addicts spend an annual $100m on the black market for narcotics, almost as much as the administration's total revenue from duties on liquor, tobacco, and oil products. The number of drug addicts there is estimated at 100,000 out of a 4.3m population.

Illicit opiate drugs in the colony largely originate from the Golden Triangle, where the borders of Burma, Laos and Thailand meet, and are transported by air or sea, in bulk and by couriers. The problem therefore cannot be solved by internal means alone.

A Hong Kong police officer with the British embassy in Bangkok is working in conjunction with Thai authorities and United States drug enforcement administration to stamp out the flow of drugs to the colony. Another Hong Kong officer is permanently stationed at Interpol's headquarters in Paris, helping to combat the flow of drugs.

New Books

by RON HALL

Sane Asylum: Inside the Delancey Street Foundation

. . . by Charles Hampden-Turner

The author presents an account of the programs and people who are part of this halfway house for some 300 ex-cons and addicts. Residents own and operate their own businesses, maintain their own credit union and accredited high school, and direct their own psychotherapy through group sessions. It is suggested that the success of the program in returning members to society with qualifications, jobs, and credit, is the unique blend of political, economic, and psychological components.

(San Francisco Book Co., 2311 Fillmore St., San Francisco, Cal., 94115. 1976. 304 p.)

Other Books

Doing Drug Education: The Role of the Teacher — National Institute on Drug Abuse. US Government Printing Office, Washington, DC, 1975. 25p.

Why Evaluate Drug Education? — National Institute on Drug Abuse. US Government Printing Office, Washington, DC, 1975. 32p.

The Second Opium War — Lamour, Catherine, and Lamberti, Michael, R. Allen Lane, London, 1974. Drug's supply routes, opium and the war, drugs and the non-aligned nations, political and economic aspects. 278p.

Why Our Children Drink — Addeo, Edmond G., and Addeo, Jovita Reichling. Prentice-Hall Inc., Englewood Cliffs, 1975. Scope of the problems, what to do. 191p.

The Economic Cost of Alcohol Abuse and Alcoholism, 1971 — Berry, R. E., and Boland, J. P. National Technical Information Service, Springfield, 1974. Lost production costs, accident costs, health care costs, research costs.

Women and Psychoactive Drug Use: An Interim Annotated Bibliography — Green, Deidre, Macdonal, Maggies, Weise, C. E., Price, S. F., and Mulloy, C. T. (compilers). Addiction Research Foundation, Toronto, 1976. 177p.

Fetal alcohol syndrome

Cardiac defects in 50%

NEW ORLEANS — About half the children born to alcoholic mothers may have heart disease, along with their other troubles.

Cardiac defects now appear to be an important part of the so-called fetal alcohol syndrome.

This unhappy news was revealed here to a session of the American College of Cardiology by Dr Jacqueline A. Noonan of the University of Kentucky in Lexington.

"Although cardiac defects have been suspected in over half the patients with the fetal alcohol syndrome, in only two cases prior to the present report has the exact cardiac lesion been identified," she told the meeting.

Of the five patients she's seen in Kentucky, only one patient with the fetal alcohol syndrome has no evidence of heart trouble. Three have Tetrology of Fallot which had to be surgically treated and one had a combination of a patent ductus arteriosus and a ventricular septal defect.

The two previous reports of cardiac lesions involved a ventricular septal defect found at post mortem, and an atrial septal defect diagnosed by cardiac catheterization.

A review of 21 cases of fetal alcohol syndrome, however, along with her five cases, showed that "in 13 a cardiac defect was suspected".

Dr Noonan said no explanation for the high number of cases of Tetrology of Fallot in these infants can be given yet. However, its discovery should "alert pediatric cardiologists to this interesting, newly-described syndrome, since it does represent a preventable cause of congenital cardiac defects".

Some children of alcoholic mothers may also have a mild form of the fetal alcohol syndrome which goes unrecognized as such.

"Such children may present for developmental evaluation later on in life because of their failure to thrive, and slow mental development. It is also likely a number will be seen by a pediatric cardiologist because of the high incidence of associated cardiac defects."

The fetal alcohol syndrome was first described in the offspring of chronic alcoholic mothers in 1973, and is characterized by a delay in development, growth retardation, and typical facies which include short palpebral fissures, a small head, relative hypoplasia of the maxillary area and frequently drooping eyelids, or ptosis.

In her survey of 24 patients, Dr Noonan found there was prenatal growth retardation in 21, and in all of the babies there was a failure to thrive after birth.

Fifteen of 24 were severely retarded developmentally, and eight to a mild degree. Only one had a normal IQ. Twenty-one of the 24 had microcephaly, and 23 had the short palpebral fissures. One-third had assymetric ptosis, and more than half had retarded development of the maxilla. Two had cleft palate, and five, a dislocated hip.

Her study also showed varying degrees of severity. When very severe, the condition has to be differentiated from a number of other syndromes such as Trisomy 18, the Cornelia-de-Lange syndrome, the Noonan syndrome, and the Rubella syndrome.

'Students' flunk on alcohol

WELLINGTON, NZ — Ignorance of the most elementary facts about the effect of alcohol on driving skills was noted in several students participating in New Zealand's first re-education courses for drunken drivers.

The Salvation Army conducted the three pilot courses, based on the DWI Phoenix Counter-Attack program. Courts directed convicted drivers to attend the four two-hour sessions.

Major Noel C. Manson, superintendent of the Army's alcoholism treatment program, has recommended that the ministry of transport should establish courses throughout the country.

Coming Events

To provide our readers with adequate notice of forthcoming events, please send announcements as early as possible to: **The Journal, 33 Russell St., Toronto, Ont., M5S 2S1.**

August

The Problems and Promise of University Based Employee Assistance Programs — Aug 1-3, 1976, Columbia, Missouri. Information: Employee Assistance Program, 215 Columbia Professional Building, Columbia, Miss., 65201.

11th International Conference on Medical and Biological Engineering — Aug. 2-6, 1976, Ottawa, Ontario. Information: Conference Office, National Research Council, Ottawa, Ont., K1A 0R6.

International Doctors in Alcoholics Anonymous — Aug. 5-8, 1976, Los Angeles, California. Information: Lewis K. Reed, MD, Secretary IDAA, 1950 Volney Rd., Youngstown, Ohio, 44511.

17th Institute on Addiction Studies — Aug. 15-20, 1976, McMaster University, Hamilton, Ontario. Information: David E. Reeve, Alcohol and Drug Concerns Inc., 15 Gervais Dr, Suite 603, Don Mills, Ont.

Symposium on Drug Dependence, Alcoholism and Criminality — Aug. 16-20, 1976, Sao Paulo, Brazil. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

2nd World Congress of the International Commission for Prevention of Alcoholism — Aug. 22-27, 1976, Acapulco, Mexico. Information: ICFPA, 6830 Laurel St., NW, Washington, DC, 20012.

9th International Conference on Health Education — Aug. 29-Sept. 2, 1976, Ottawa, Ontario. Information: Canada's Organizing Committee, 9th International Conference on Health Education, Canadian Health Specialists Society, PO Box 2305, Station D, Ottawa, Ont, K1P 5K0.

September

2nd International Symposium on Victimology — Sept. 5-11, 1976, Boston, Massachusetts. Information: 156 Federal St., Boston, Mass.

27th Annual Meeting of Alcohol and Drug Problems Association of North America — Sept. 12-16, 1976, New Orleans, Louisiana. Information: ADPA, 1101 15th St., NW, Washington, DC, 20005.

AADAC, School on Alcohol and Drugs — Sept. 22-23, 1976, Calgary, Alberta. Information: Sharon Fogarty, Conference Coordinator, AADAC, School on Alcohol and Drugs, 812-16th Ave., SW, Calgary, Alta., T2R 0T2.

Alcoholism: Advances in Medical and Psychiatric Understanding — Sept. 25-29, 1976, London, England. Information: Alcohol Education Centre Ltd., The Maudsley Hospital, 99, Denmark Hill, London, SE5 8AZ.

First World Conference on Therapeutic Communities — Sept. 27-Oct. 1, 1976 — Katrineholm, Sweden. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

October

Familie und Suchterkrankung — Oct. 4-7, 1976, Dusseldorf, Germany. Information: DHS, D-47 Hamm, Postfach 109, German Federal Republic.

2nd International Symposium on Alcohol and Aldehyde Metabolism — Oct. 16-17, 1976, Philadelphia, Pennsylvania. Information: Dr R. G. Thurman, 409 Anatomy-Chemistry Building, University of Philadelphia, Philadelphia, PA, 19174.

4th Congress of the Comite National de Defense Contre L'alcoolisme — Oct. 14-16, 1976, Strasbourg, France. Information: ICAA, Case Postale 140, 1001 Lausanne. Switzerland.

Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct. 20-23, 1976, San Diego, California. Information: Pamela Maroe, ALMACA, Suite 410, Reston International Center, 11800 Sunrise Valley Dr., Reston, Va., 22091.

Ontario Hospital Association Annual Convention — Oct. 25-27, 1976, Toronto, Ontario. Information: Hilary Short, Ontario Hospital Association, 150 Ferrand Drive, Don Mills, Ont. M3C 1H6.

20th Annual Conference of the American Association for Automotive Medicine — Oct. 31-Nov. 3, 1976 — Atlanta, Georgia. Information: James Fell, National Highway Traffic Safety Administration, N43-32, 400-7th St., SW, Washington, DC, 20590.

November

International Conference on Alcoholism and Drug Abuse — Nov. 13-18, 1976 — Baghdad, Iraq. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

1977

7th International Conference on Alcohol, Drugs, and Traffic Safety — Jan. 23-28, 1977. Melbourne, Australia. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Positions Available

Although a national airline strike crippled transportation, more than 600 people attended INFORMACTION, the 11th annual conference of the Canadian Foundation on Alcohol and Drug Dependencies. This month The Back Page features candid shots of some of the participants . . .

Informaction candids

. . . Richard Boczkowski, St. John's Newfoundland, Department of Health . .

. . . Doreen Birchmore, Donwood Institute, Toronto .

. . . Robert Lindsay, Division of Mission, United Church of Canada . . .

. . . Roberta Ferrence, Lake Erie region, Addiction Research Foundation . . .

THE BACK PAGE

Photos by Toby Barrett

. . . David Reeve (left) and Garwin Martin, Alcohol and Drug Concerns, Toronto . . .

. . . David Archibald, executive director, Addiction Research Foundation . . .

. . . Nicholas Choul (left), University Medical Center, West Virginia and Alec Gabe, ARF . .

The Journal

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Pot bill nears death by neglect

By Bryne Carruthers

OTTAWA — The federal government has decided to let the long-awaited bill to reduce penalties for possession of marijuana to die on the order paper in October when the current session of Parliament ends.

This is despite the fact the controversial bill has already been passed and amended after lengthly debate by the Senate.

Mitchell Sharp, president of the Privy Council, told **The Journal** it is highly unlikely a new bill will be introduced in the new session of Parliament before Christmas.

That bill, which would likely be introduced in 1977, probably just in time to be caught by an election, would either be the one approved by the Senate, or very similar, he said.

Mr Sharp explained there will be time only for three or four high priority pieces of legislation to be considered between the autumn opening of the new session of Parliament on Oct 12 and the Christmas break.

He said that much of the time during this period will be devoted to debating the speech from the throne and budget bills.

Mr Sharp indicated the government does not give the cannabis bill, originally introduced in the autumn of 1974, a high priority.

In fact, four years have elapsed since then Health Minister John Munro announced the government's intentions to reduce penalties for cannabis possession. This followed the report of the LeDain Commission of Inquiry into the Non Medical Use of Drugs.

Mr Sharp said that when the bill is reintroduced, it will have to be resubmitted and passed by the Senate as well as introduced in the Commons.

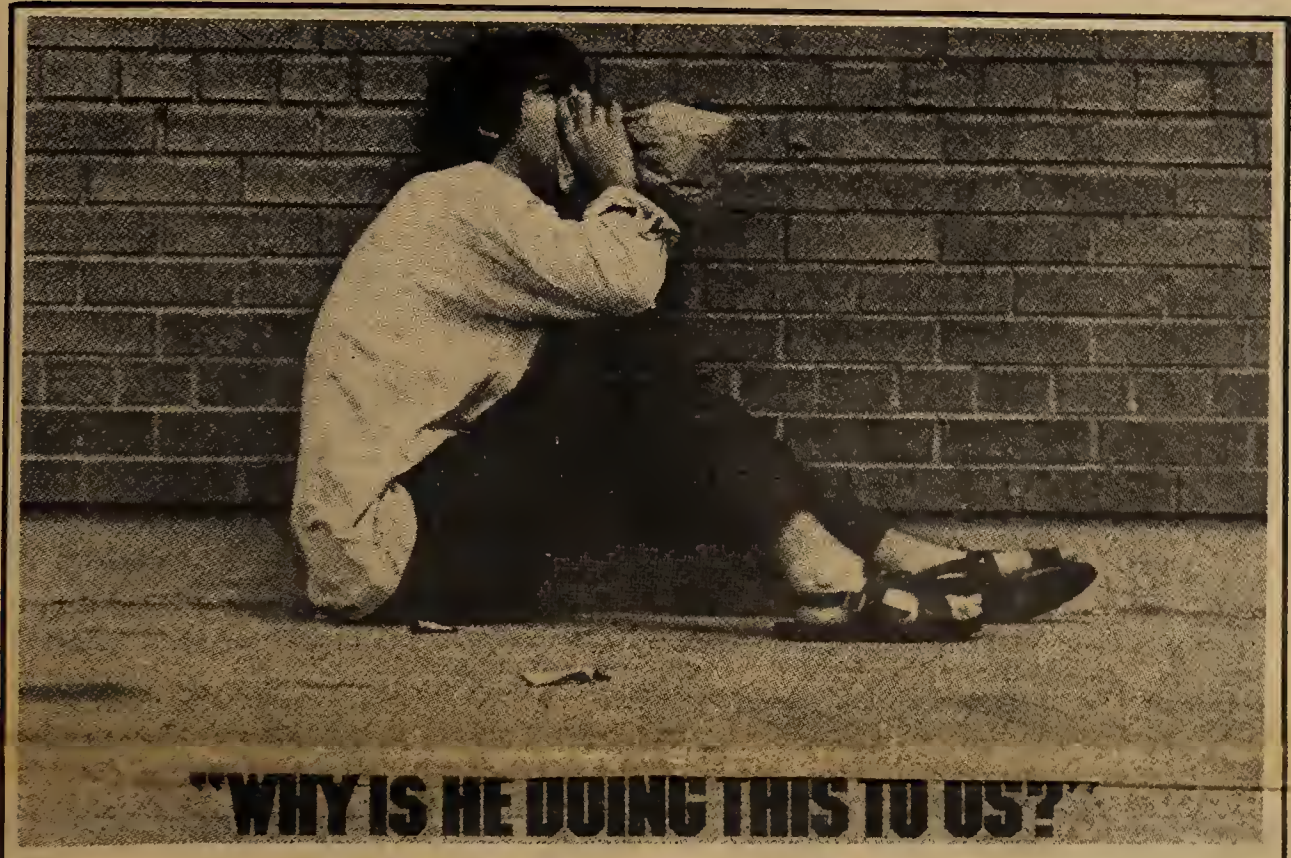
He said he hopes the Senate will not repeat the lengthy debate that accompanied consideration of the bill in the past year-and-a-half. However, the Commons will probably want to study the bill in committee.

Mr Sharp said the Liberal Government did not consider the Senate-approved bill this session, because it did not want to interject the cannabis issue into the already complex debate on the peace and security measures before the House of Commons.

The bill in question, as amended and approved by the Senate, would lighten penalties for simple cannabis possession. Maximum penalty for simple possession would be a $500 fine, compared to the current maximum penalty of a $1,000 fine or six months in jail or both.

Cannabis would then be moved from the stringent Narcotics Control Act, which covers heroin and opiates, to the Food and Drugs Act, which covers prescription drugs, hallucinogens like LSD, and amphetamines.

In recent years, many people convicted of simple possession, especially in cases of a first offence, have been given either an absolute or conditional discharge. Such discharges are technically not regarded as convictions although they do give people a criminal record.



Inhalent abuse by young people — the subject of a public awareness campaign (above) of the Canadian Mental Health Association — is also being studied by the University of Texas through a US National Health and Welfare grant. For details on the study see page 3. Poster courtesy of Mental Health Metro (Toronto).

Doctors go after drinking drivers

By Betty Lou Lee

OTTAWA — Consent to blood alcohol samples in the event of an accident should be prerequisite to obtaining a driver's licence, a Canadian Medical Association committee recommends.

The suggestion is being studied for its feasibility by a joint committee of the CMA and the Canadian Bar Association.

It came from the CMA committee on emergency medical services headed by William Ghent, chief of surgery, Hotel-Dieu Hospital, Kingston, who said breathalyzer laws are not having the desired effect of reducing impaired driving.

Under present laws, a doctor cannot take a blood sample for alcohol analysis without the signed consent of the patient, and the results of such a test cannot be given to police without the patient's consent. Blood alcohol tests are more accurate than breathalyzer samples, and may be taken from unconscious patients.

These consents would not be required if the driver had to agree to them in order to get his original licence, or a licence renewal. The consent would also cover analysis for drugs other than alcohol, and situations where driver behavior is abnormal, not just where there has been an accident.

Dr Ghent termed alcoholism the fastest growing disease in Canada, and said the combination of drinking and driving among 16- to 21-year-olds is "a national

(See — CMA — page 4)

Controlled drinking fracas

Rand Report draws critics' fire

By Milan Korcok

NEW YORK — The possibility that a recovering alcoholic might return to controlled drinking, suggested in a recent survey issued by The Rand Corporation of California, has drawn a volatile response from many physicians, researchers, and particularly the US National Council of Alcoholism.

The Report, (**The Journal**, August) entitled Alcoholism and Treatment and released in June, was prepared under a grant from the US National Institute on Alcohol Abuse and Alcoholism.

Frank Seixas, medical director of the NCA, cites "glaring" methodological deficiencies in the survey which prompted the authors to conclude that "alcoholics who were drinking socially were no more likely to relapse than those who were abstinent".

Though the study was based on a client pool of 30,000 individuals treated at 44 treatment centres, Dr Seixas emphasizes that the conclusion supporting the possibility of a return to controlled drinking was based "not on 30,000 patients, nor 10,000, nor 1,000, but to a subsample of a group of 161 patients".

"Furthermore," says Dr Seixas, "the relapses upon which this conclusion of paramount importance was made, were eight in number. Three cases out of 19 who claimed normal drinking at six months and five out of 31 who claimed abstinence at six months."

In their report, the authors David J. Armor, J. Michael Polich, and Harriet B. Stambul, specified that "in accepting normal drinking as a form of remission, we are by no means stating that alcoholics should attempt moderate drinking after treatment".

They in fact said it would still be unwise to advocate anything but abstention as a treatment goal.

But clearly, that proviso was not enough to stem the avalanche of criticism by researchers and treatment personnel to whom the prospect of controlled drinking within the treatment sequence is seen as dangerous.

Much of the criticism focusses on the length of the Rand group's follow-up periods (six months and 18 months), the lack of a random sampling for the 18-month groups, the study's reliance on patient recall of their own drinking patterns, and the high numbers of clients lost to follow-up (9,000 of 11,500).

Another of the major criticisms concerns the alleged failure to include data from the work of other prominent scientists in the field, such as Dr John Ewing of North Carolina, and Dr Max Glatt of England, neither of whom have been able to establish any number of controlled drinkers over much longer periods of time.

In response to the report, Dr Ewing, director of the Center for Alcohol Studies and professor of psychiatry at the University of North Carolina, urges extreme

(See-Publicity-page 5)

What's Inside

Sensory deprivation, tranquillity or terror? For a personal account see The Back Page.

Morris Chafetz one year down the line

Exclusive interview with the former director of the US NIAAA--Page 4

LA takes double swipe at student smokers

By Saul Abel

LOS ANGELES — The Los Angeles Unified School District, one of the largest in the United States, and the Los Angeles Board of Education, have struck a double blow in the fight against smoking.

The Board of Education has turned down a proposal to permit student smoking in specially designated areas of some high schools, and the School District has revealed plans for a five-year school health education and smoking prevention program.

The action on proposed smoking areas in certain high schools came in the wake of a measure passed by the State Legislature and signed into law by Governor Jerry Brown in May, 1975.

An identical bill passed both houses of the Legislature in 1974, but was vetoed by then Governor Ronald Reagan.

Discussion of the bill was heated and continues to be following its passage.

The new law takes a local option approach, allowing local school boards to decide whether to set aside special student smoking areas on high school campuses.

Previously, state law prohibited the use and possession of tobacco on all high school premises.

Supporters of the legislation argue that student smoking is a fact of life, and that most school restrooms are filled with smokers, and therefore unsafe for non-smokers and fire hazards.

Supporters also charge it is hypocrisy to maintain a double standard, condoning smoking by teachers and adult visitors while denying the privilege to students.

Opponents of the measure contend it is even more hypocritical to accept health education as a major responsibility of the school system and, at the same time, to allow the use of nicotine, a substance proven to contribute significantly to lung cancer and heart disease.

The "smoking area" legislation also directs local school authorities to take all steps deemed practical to discourage high school students from smoking.

Los Angeles has initiated plans for such an anti-smoking campaign, expanding its scope to include fifth through ninth graders in 48 elementary schools and nine junior high schools, as well as in six high schools.

Designated the School Health Education and Smoking Prevention (SHESP) Program, the campaign is geared to community cancer control, and adopts certain features of a similar program in San Diego that achieved considerable success (**The Journal**, February, 1975).

The San Diego program, over a five-year span, produced substantial reductions in cigarette smoking among junior and senior high school students during a period when smoking was increasing nationally among the same age groups.

SHESP will place heavier emphasis than the San Diego program on peer group instruction, according to Ruth Rich of the Health Education Section, Instructional Planning Division, who is responsible for implementation and operation of the program.

"Peer pressure is a significant factor in influencing young people to start smoking," Dr Rich told **The Journal**.

"If it can *induce* them to start, then it can help to *prevent* them from starting, so we'll train students to talk to other students.

"The student speakers will have status with their audience, since they will be from the same school."

About 25 to 30 students will be selected in each high school to receive intensive training for three to four weeks. The students will get classroom credit for this training from teacher-sponsors on assignment to SHESP.

A similar peer-structured program has been effective in the field of venereal disease prevention, Dr Rich said.

There will also be a vocational component in the program, since it will serve to interest some students in going on to pursue health careers.

The program is expected to involve more than 73,000 students — about 10% of the total enrolment in the Los Angeles Unified School District.

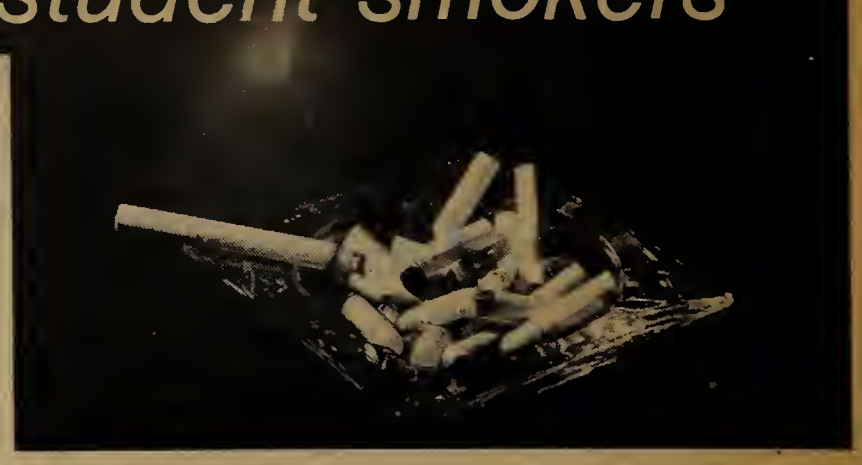
The choice of grades five through nine was made because statistics indicate most student smokers have taken up the habit by age 13, Dr Rich explained. The peer instructor teams will present their educational programs on the hazards of smoking to these grades and to their fellow high school students.

Research has shown that in their mid-teens, 30% of the boys and 27% of the girls are regular smokers, Dr Rich said. The SHESP goal is to reduce this percentage by one-fourth to one-half.

SHESP will be a five-year program, beginning in early 1977. Like the San Diego program, it will be sponsored by a consortium of agencies and organizations. Known as Community Cancer Control, the consortium consists of the University of California at Los Angeles, the University of Southern California, the Charles Drew Postgraduate Medical School, and the American Cancer Society.

The consortium has received a government planning grant to design the program, and has requested the support and participation of the Los Angeles Unified School District in planning and implementation.

District Superintendent William J. Johnston said a project proposal has been submitted to the National Cancer Institute, and he anticipates that agency will fund the program for the first year by a grant of approximately $71,000. This amount will be matched by in-kind contribution by the school district to make up the total program budget of $142,000 for the first year.



Spiked brew for starters at Irish medical meeting

DUBLIN — Doctors should have been forewarned when they received a conference survival kit upon registration for the joint annual scientific meeting of the Canadian, Irish, and British Medical Associations held here in Eire's capital.

Distributed by a pharmaceutical company, the kit contained an assortment of morning-after analgesics and antacids, along with a message of fond hope they wouldn't be needed.

But in a city where watering holes can outnumber any other type of commercial establishment in a city block, and where there appears to be a national preoccupation with "the pint" or "the jar", it may also have been a faint hope.

At the meeting itself, on the Belfield campus of University College, Dublin, there were some major differences from a Canadian medical convention. At home, Canadian doctors are accustomed to free coffee in the exhibitors' area, often provided by a drug company.

In Dublin, home of Europe's largest brewery, there was also free Guinness, which flowed like the Irish sea, and a cash bar where Irish — not Scotch — whisky was sold.

Perhaps contrary to public belief, alcohol is practically unknown during working hours in press rooms at Canadian medical conferences. Not so in Dublin. By mid-morning charming Irish women were taking orders for refreshments.

"Coffee, please," would come the automatic reply from the Canadian medical writers.

"Regular or Irish?" asked the waitress.

"You mean Irish with whisky in it?"

"Well yes," she'd smile.

The Canadians stuck to regular.

Only four are ready to go

Provinces split on spot breath checks

OTTAWA — Only four of Canada's 10 provinces are prepared to launch the recently authorized roadside breath checks starting this summer, according to the federal justice department.

The names of the cooperating provinces haven't yet been released. But some of the holdouts, notably British Columbia, feel the costs of the program make it of questionable value, especially in light of other provincial options.

The only roadside testing machine approved by the federal government to date, carries a $500 price tag. More important, each bottle of breath samples will cost about $5, with one required for the police and a duplicate for the suspect.

The spotty application of the roadside breath checks, authorized by parliament last spring, could end up undermining the federal initiative, with drunk drivers in some provinces being convicted on the basis of roadside tests that aren't being used in neighboring provinces.

In theory, the roadside test is only supposed to be used to indicate to a policeman whether a driver is drunk enough to warrant a formal police station breath test, which could then be used as evidence in a court case.

The roadside test results aren't supposed to be used as evidence in court, according to federal justice officials. It's reported, however, that some provincial officials are already concerned that roadside test evidence will start cropping up in court cases. Refusal to take a road test could result in fines or jail penalties similar to those imposed for refusing a formal police station test.

In another complication, only one province, Alberta, has said it would provide alcoholism treatment facilities for impaired drivers that would allow a court judge to grant conditional discharges on the condition that the person convicted of impaired driving receive proper treatment.

Professor Bottomsworthy on 'touching' people

By Wayne Howell

REMEMBER PARTICIPACTION? Now Health and Welfare — never a federal ministry hesitant to rush in where the British North America Act says it should not tread — plans to bring us Alcoholaction. A national information program called Dialogue on Drinking will be launched this fall according to Health Minister Marc Lalonde.

Professor Bottomsworthy, that erudite and astute observer of the passing scene, is quite enthusiastic about the project.

"This ad campaign," he told me, "is going to have IMPACT. A campaign of this nature is bound to reach out and TOUCH Canadians in many walks of life. And that's what it's all about."

"How so?" I asked.

"For instance, the owners of certain advertising agencies are going to be touched. Deeply touched. It is national ad campaigns such as this that make them view debts left over from previous election campaigns in a much more favorable light," he said.

"I hadn't thought of that."

"Furthermore, a campaign such as this touches the aesthetic nerves of our copy writers and art directors; it allows them to exercise their creative talents with arty public service promos instead of with crass commercial messages. Why it even allows our professional photographers to hone their side-lighting and back-lighting skills on glasses of spirits in the interests of the public good, for a change."

"But surely," I protested, "this is peripheral. How is Dialogue on Drinking really going to touch people?"

"Well think of all the people in Canada's struggling magazine industry. A healthy Canadian magazine industry cannot live on Air Canada and CBC ads alone. This ad campaign will do wonders for their morale, will touch them where they love to be touched. Time magazine may still get the Gilbey's Black Velvet ads but by God, and with the help of Hugh Faulkner, they won't get any of these! I tell you, this is a far, far better thing that Health and Welfare does than it has ever done before."

The professor paused to wipe a tear from his eye. I could see that this man, so oft reviled, so oft accused of cynicism and skepticism, I could see that he too was touched. But only for a moment, for he continued.

"Then, of course, there are the owners of the daily press. And the significance of big government ad campaigns to the ethnic press is so well known and has been so extensively commented upon that I wasn't even going to mention it."

"But when you spoke of IMPACT, of TOUCHING people, I thought you meant . . . . ."

"Of course, of course," he interrupted, "I was just getting to that. A federal ad campaign like this naturally touches the people that own our private television stations. It strengthens them in the fight against the American commercial giants and from that we all stand to benefit. I tell you, the ramifications of a thing like this take one's breath away," he said . . . breathlessly.

I started to see the possibilities.

"Is it not conceivable," I interjected, "that this ad campaign might even touch the man in the street, might make him more aware of the dangers of high levels of alcohol consumption, might inculcate in him the positive virtues of responsibility and sobriety?"

"O come on . . . .," chuckled the professor, "did people stop smoking because of all those cute ads Health and Welfare put up on the Post Office bulletin boards?"

(Wayne Howell is an Ottawa physician and freelance writer.)

Leave drinking age alone, say Canadian MDs

OTTAWA — Canada's doctors are against raising the legal drinking age to at least 21.

A motion to raise the age failed to get approval of the general council of the Canadian Medical Association, the profession's parliament, at its annual meeting.

Dr Donald J. Farquhar of Vancouver, who made the motion, said the recent lowering of the drinking age in all provinces was a retrogressive step that had increased the accessibility of alcohol to young people.

His seconder, Dr Michael C. Petreman, medical coordinator, Nanaimo Regional General Hospital, BC, said the thrust of the motion wasn't to prevent 18-year-olds from drinking, but to limit access to alcohol of 12- and 13-year-olds who could pass for 18, but not 21.

There was long debate among the 125 doctor delegates from across Canada, before the motion to urge raising the age limit was defeated.

Dr Lloyd Grisdale, Chairman, department of ambulatory patient care, University Hospital, Edmonton, and past president of the CMA, said he didn't understand the reluctance of the council to deal with the issue. In his province, the year after the age was lowered to 18 from 21, traffic deaths increased 118% for the 14-to 19-year-old group.

Dr Robert F. Clark, executive director of the Alberta Medical Association, said there may have been a peak of abuse after the age was lowered, "but kids have to learn how to drink like they have to learn other things. . . . Let's treat them like adults, which they are, and use persuasion and other ways, rather than legislation .... We're not giving this group the respect they're entitled to."

Other speakers referred to the inconsistency of having 18 the age of majority for everything but drinking.

One doctor said his 19-year-old daughter would "laugh me out of court" if such a motion were passed. "Such a law is completely unenforceable, and leads to disrespect for the law. We already have too much of that."

Robert E. Hatfield, assistant professor, department of medicine, University of Calgary, who said he spoke from a biased position because he was a non-drinker, suggested the "best way to influence the young is to model the behavior you wish to obtain. We're hoping to get someone else to do what we're not willing to do ourselves."

It should come as no surprise that young people drink when they are in an adult culture "that uses alcohol liberally and has an extreme financial interest in it," Dr Hatfield said. The young also find ways to circumvent laws, as adults do, "and they find them early".

He said when doctors altered their smoking habits in response to scientific data about the health hazards, they then had a firm base on which to make statements, and they were having some impact on older smokers, if not young ones.

In contrast to the long debate on the drinking age, there was little discussion before passing a motion calling for a comprehensive CMA study of the problems of heroin and cocaine use. The study group will be asked to make recommendations to the general council.

L. Jack Genesove of Toronto, head of the department of Family Practice at North York's Branson Hospital, however, thought it would be of better use to study the two major addictive problems in Canada — alcohol and tobacco.

The general practitioner said: "You and I see the odd heroin user with jaundice, and maybe the odd nose problem with cocaine, but we see a lot of problems with alcohol and tobacco.

"We should leave it to the FBI and the Mounties to worry about the kind of things that keep bureaucracy going.

"We got into trouble with heroin only when we started restricting it," said Dr Genesove.

The CMA will also encourage doctors to use restraint in prescribing minor tranquillizers and hypnotics.

Its committee on the non-medical use of drugs noted that use and abuse of these products has become widespread, "and any attempt to control the abuse . . . must be brought about by an altering of the prescribing habits of physicians".

Last year, the CMA general council suggested that these drugs be placed in Schedule G to restrict their use. The non-medical use of drugs committee said in its report this year it appreciated concerns expressed by the director of the Bureau of Dangerous Drugs about the increased manpower and expense necessary if such a resolution were implemented. But the Health Protection Branch is still studying the matter.

Zinc deficit suggested in alcohol cirrhosis

By Dorothy Trainor

MONTREAL — Zinc has been found to be important in the metabolism of alcohol and zinc depletion may play a role in the development of alcoholic cirrhosis.

Zinc is an integral part of the body's enzyme activity and in alcoholic cirrhosis and other types of liver disease, there is an increase of zinc excreted in the urine, James C. Smith told an American College of Nutrition symposium in Montreal.

Dr Smith is chief of the Trace Metal Research Division, Veterans Administration Hospital, Washington, DC.

"In patients who have died of cirrhosis and in living cirrhotic patients, there has been demonstrated a marked depression of tissue zinc found in the liver."

Various factors, he said, make the liver susceptible to alcohol damage. With respect to this damage, there may also be an inter-relationship between zinc and vitamin A.

"As early as the 1930s, research papers have raised the question whether liver disease is a vitamin A deficiency disease. They have pointed out that liver concentration of vitamin A is depressed in such patients."

It has since been shown that cirrhosis of the liver is usually accompanied by low serum zinc. Thus, metabolized zinc may have been limited in those patients studied, he said.

"There is other indirect — and only indirect — evidence that there is a relationship between vitamin A and zinc."

At University of Texas

Inhalent use to be studied

DALLAS, Tex. — Backed by a $420,000 grant from the Department of Health, Education and Welfare, psychologists at the University of Texas Health Science Centre here have launched a research project to study inhalant abuse by young people.

They also plan and apply techniques for changing the drug behavior of heavy inhalant abusers.

Maurice Korman, chairman of the division of psychology in the university's department of psychiatry, is the principal investigator. Dr Manuel Balbona, a member of the clinical faculty in psychology, and director of the Adolescent Centre at Terrell State Hospital, is co-investigator. Other members of the team are PhD candidates in clinical psychology.

The impetus for the project came partly from a widely publicized case in which three young people were found dead in a closed car with a tank of nitrous oxide — laughing gas — on the floor.

Maurice Korman

Says Dr Korman: "Heavy usage of inhalants is a dangerous habit because of the rapid loss of control that can lead to overdosage and death from suffocation or from various medical complications or from aecidents due to impaired judgment."

The young child sniffing cement glue from a bag is in as much danger of dying as the teenager who sniffs laughing gas, Dr Korman stresses.

The University of Texas psychologist says people in the 10-15 year age range are the heaviest abusers, although older teenagers are also involved.

"It is probably fair to say that some 5% of the junior and senior high school populations in Dallas are relatively frequent users of inhalants," he adds.

Very little is known about the long-term medical and psychological consequences of heavy inhalant usage, Dr Korman says, and he is hopeful his projeet will elarify some of the unanswered questions. The study is probing patterns of use, the roles of peers and families, and the effects of chronic use.

Another aim of the projeet is to provide psychological services to heavy abusers in all areas of Dallas.

Working with small groups of from eight to 10 youths, the psychologists concentrate on teaching "living skills" — how to get along with people, how to solve problems in daily life and "how to be who (you) want to be".

The researchers believe if the young people are able to improve these skills, they will no longer feel the need to resort to inhalants in order to be "out of it" temporarily.

Teehniques being used with the small groups include viewing tapes, experienee-sharing, role playing, and practising the "living skills" within the safety of the group.

"The project is also concentrating on the factors that proteet some young people from becoming heavy users, even though they are exposed and are at high risk," says Dr Korman.

"We want to know, for example, why some become heavy users and then give it up. We want to look at the strengths of the young people and their families as well as the weaknesses."

An important part of the project involves evaluating the effectiveness of techniques for changing the drug behavior of the young people. Control groups of heavy inhalant abusers who do not receive psychologieal help, are used. The investigators are examining the pattern of drug use and changes in family and peer relationships in both groups.

Vegetable team gains popularity

OTTAWA — The Federal Health Department's innovative story book for children, aimed at instilling positive values to reject drug use, is slowly gaining popularity in pilot projects in schools and school boards across the country.

The illustrated book, *A Hole in the Fence*, was originally unveiled in 1975, and features a cast of 20 characters, all vegetables except the fungus, Mr Mushroom. In essence a modern fable, the story book details how 'magic potions' are not problem-solvers, and instills value lessons against cheating, lying, and stealing.)

Carrot and Mr Mushroom

Mr Cabbage and Corn

In Ontario, the Ottawa Roman Catholic School Board, the Stormont-Dundas-Glengarry School Board, the Carleton Roman Catholic School Board, and the Prescott-Russell School Board have all ordered copies for test use this fall. The Carleton Board, for example, has ordered 250 French and 50 English versions of the book.

In Manitoba, tests are being conducted in three school districts using the French language version of the vegetable character story books.

But the books are being used for more than drug abuse education; they are also being used experimentally for a broader-based approach to teaching children about values.

Manitoba officials are working with the Non Medical Use of Drugs Directorate to develop a spin-off project using the values-based approach but not using the federal government's cast of zany and sometime diabolical vegetables.

Mr Cauliflower

Pea and Bean

While the introduction of the story book is occuring at a slower pace than hoped for, the government is eneouraged enough to begin a second printing of 2,000 books — this time with only one supplemental volume, containing the original teaching and activity guides.

The government says it has received a number of inquiries from other countries, including the United States, Bermuda, and Australia, as well as from private teachers across Canada.

Potato

In Nova Scotia, the province's Commission on Drug Dependence, is cooperating with schools to test the story books, using some 600 copies obtained from Ottawa. Saskatchewan's provincial alcohol commission has arranged a pilot project in Swift Current.

Onion

The Non Medical Use of Drugs Directorate plans to spread its use of educational tools for combating drug abuse, keeping in mind federal health Minister Marc Lalonde's recent exhortations to inerease the use of school systems to combat alcohol as well as drug abuse.

Former US NIAAA Director Morris Chafetz

Alcohol workers must deny the temptation to play God

By Charles Marwick

WASHINGTON — Despite considerable improvement in attitudes, there is still so much stigma attached to alcoholism that changes in the financing of alcoholism rehabilitation program must be undertaken cautiosly and their implications weighed carefully.

This is the view of Morris E. Chafetz, former director of the US National Institute on Alcohol Abuse and Alcoholism (NIAAA) and now principal research scientist at the Metropolitan Center for Planning and Research at Johns Hopkins University.

In an exclusive interview with **The Journal**, Dr Chafetz said: "Alcoholism still carries that old stigma among more people than I care to admit. Despite all the progress, when it comes down to it, the old prejudices still rear their heads."

While Dr Chafetz was primarily addressing the situation in the United States, his view that attitudes to alcoholics have not changed significantly, has obvious implications for alcoholism treatment programs elsewhere.

Because of these attitudes, Dr Chafetz is against haste in changing the funding mechanisms of the various state alcoholism programs in this country to a block grant system.

Under such a block grant arrangement, the individual states receive funds for various health programs including alcoholism which they then distribute themselves. Dr Chafetz is afraid that in such circumstances and because attitudes to alcoholism have not changed sufficiently for the better, "alcoholism programs will inevitably get the short end of the stick".

'I would be absolutely naive if I thought we had overcome the hurdles of removing the stigma of alcoholism. . .'

"Now this is not to say that the states' alcoholism programs have failed to make progress," Dr Chafetz went on. "On the contrary, I have been delighted with what these programs have achieved so far and I have gone on record as saying so.

"Neither am I questioning the abilities of the individual states to manage their own alcoholism programs effectively. Alcoholism programs have made great progress in this country as far as visiblity, credibility and the commitment of resources are concerned. But I would be absolutely naive if I thought we had overcome the hurdles of removing the stigma of alcoholism or of thinking that, in a competition for resources with a wide variety of more acceptable and, if you will, respectable health programs, alcoholism could hold its own."

Because of this, Dr Chafetz holds that it would be folly to switch funding of health program (including alcoholism) to the block grant system.

Enlarging on this theme, Dr Chafetz said: "Certainly I'm not unsophisticated in this field and yet I continue to be amazed at the virulence and disrespect most people innately feel toward sick alcoholic people. Having been in the field as long as I have, 23 years, I am, I believe, objectively sensitized to the implicit and explicit put-downs that these people experience — both from the general public and from those who work in the field."

Dr Chafetz called on those working in alcoholic treatment programs to resist the temptation to play God and to deal with the alcoholic honestly.

"I am a northerner, a New Englander born and raised," he continued, "and I used to take a certain amount of smug satisfaction at how the white southerner in the US treated black people.

"Then, when the black versus white issues reared their heads in the north, I was embarrassed and ashamed to see how the so-called liberal cities dealt with them. I'm convinced now that in dealing with blacks, the southern white community was more honest than the northern white community.

"In the same way, I feel that society in general must deal with the alcoholism issue in a more reasonable and honest way than is presently done by those who wave the flag as workers in the field of alcoholism.

"I left NIAAA in part because I promised my family I wouldn't stay more than five years. But I would have left anyway, even without that promise. When you are head of a powerful organization such as NIAAA with such tremendous resources at your disposal, after a time your statements and utterances begin to be accepted as gospel. I know how seductive my own ideas and words can be and I consider that dangerous. That's why I left.

"One of the things I notice about some of the leaders of organizations dealing with alcoholism is that they have been in positions of power for far too long. I have watched some of these people try to make over recovering alcoholic individuals in their own image and there are occasions when I'm afraid maybe they are playing God and it worries me."

Another aspect of the alcoholism problem discussed by Dr Chafetz was the disproportionate funding it receives compared with other drug abuse programs.

"All the other drug abuse programs get five dollars for every one that is spent on alcoholism, if I remember correctly," he said. "Yet alcoholism is 10 to one in terms of incidence compared with all the other drug abuse problems combined.

"Since everyone agrees alcoholism is a major drug problem why should this be so?" Dr Chafetz asked. "I think there is a very good reason. Things which are unfamiliar to us and therefore most threatening generate more enthusiastic efforts to combat them than do problems that are familiar such as alcoholism.

"I remember when I was teaching at medical school, if you had an unusual clinical case then students would spend days on it. They'd go 48 hours without sleep, giving their all to the problem. But if you had a case that they would be likely to see almost everyday, then you could never generate that kind of enthusiasm. Alcohol is our drug, it's everyone's drug. So we tend not to get excited about the problems it causes even although they are so devastating."

Regarding the future, Dr Chafetz said he was looking forward to the eventual disappearance of a separate categorical program for alcoholism.

"When I was NIAAA director, I was once asked how I would know that the Alcoholism Institute was a success. I responded by saying that when there was no longer a need for it because alcoholics were being treated by the health care system as any other sick person would be, I'd know.

"As more and more we show how alcoholics can successfully respond to treatment; as we move toward programs which reach the alcoholics earlier in their illness — which in turn means even greater treatment successes at lower cost; as the stigma of alcoholism is removed; when all these things happen, then much of the treatment of alcoholics will be come part of the general health care delivery system, which is where it ought to be.

"Other things being equal there should not be a separate categorical program for alcoholism because it is part of the general health condition

"But this does not mean that we should do away with alcoholism programs today. That is the goal. But it is not the reality we face today."

'Alcohol is everyone's drug. So we tend not to get excited about the problems it causes although they are so devastating . . .'

Alcoholism a disease

CMA finally relents its position

(From page 1)

tragedy. They have the highest accident rate."

With automatic consent to blood tests, "we could finally get a hard set of facts about people involved in accidents," Dr Ghent said. Drivers have the responsibility for controlling 1½ tons of steel at 70 miles an hour, and the "non-drinking and good driver deserves more protection than he has been afforded in the past."

At the annual meeting of its general council, or parliament, the CMA also got around to officially recognizing alcoholism as a disease.

Its non-medical use of drugs committee noted that in 1974, the council passed motions "that went part way to agreeing that it was a condition requiring treatment, and that euphemisms should be discarded when making the diagnosis of alcoholism".

This time it went all the way, and joined the American Medical Association, World Health Organization, American Hospital Association, and American Public Health Association with its official recognition of the disease.

At the same time, it passed a motion to "stress the value of active participation by the medical profession in all aspects of treatment of alcohol dependence and misuse".

The non-medical use of drugs committee, headed by psychiatrist Dr Lionel Solursh of Toronto, noted that "alcohol treatment programs are more and more prone to the downplaying of medical involvement.

"Physicians, by virtue of their training and experience, have much to contribute in research, education, diagnosis, counselling, psychotherapies, management of secondary health problems, and leadership of the health care team."

The committee saw this "downplaying" as part of a more fundamental problem — "the inroads being made into medicine by non-physicians.

"It is becoming obvious that certain aspects of medical care, e.g. training of ambulance personnel, treatment of alcoholism, are being taken over by non-physicians, partly owing to omission on the part of physicians to become involved. Alcoholism is being labelled as a social disease and there are attempts to effect a cure excluding medicine."

Most strategies relate to 'bums' but most alcoholics are 'normal'

SAN FRANCISCO — How can people get "high" without some form of drug?

Finding answers to that question should be a major future goal for the treatment of all kinds of addiction, in the opinion of Charles Becker, director of the division of clinical pharmacology at San Francisco General Hospital.

Charles Becker

At the recent conference, Alcoholism and Drug Abuse 1976, Dr Becker emphasized the need to find non-self-destructive options to drugs and suggested athletics and group fellowship as possible ones.

"It is my personal belief that you have to give something in return to get rid of an addiction," he said. "Linking the body and the mind are important. This is a legitimate need for the patient but physicians rarely address the issue," he told the meeting.

Dr Becker, head of the alcoholism unit at the hospital, noted the difficulty of defining and identifying an alcoholic.

Most addicts have a poly-drug problem, he continued. "Have you ever seen a heroin addict who is not an alcoholic or a smokeaholic?" he asked.

Most strategies, he said, relate to "bums," who are only a small fraction of the alcoholism problem. Attempts to categorize alcoholics as pseudo-psychopathic, delinquent, or neurotic are also meaningless since most alcoholics "are essentially normal". However, many alcoholics have self-destructive habits and will not take responsibility for their own care.

For some alcoholics, pharmacological assists can be useful, Dr Becker said, but he emphasized that "most experience is anecdotal. The literature doesn't justify the widespread use of any drugs".

Also, he noted, the pharmaceutical effectiveness of a drug is related to "who passes it out and what a patient expects. If a therapist thinks a drug is useful, it will work 30% better".

Halfway houses for alcoholics

Rules should be few but strictly enforced

By Walter Nagel

EDMONTON — The best halfway houses have a minimum of rules, but absolutely insist upon those, a veteran in the field has said here.

James Carroll of Fitchville, Conn., an administrator in community resources programs run by a large psychiatric hospital in his state, said a "back-to-basics" guiding philosophy and common sense are key ingredients if such facilities are to function well.

In a practical "do-and don't" session of advice to halfway house operators, Mr Carroll said residents should help themselves as much as possible; there should be an emphasis upon plenty of simple, nourishing food; health services should be available; rapport should be developed with police and other service agencies; and there must be anticipation of skepticism and even antipathy from the community.

Among his suggestions to the Association of Halfway House Alcoholism Programs of North America, Inc.:

• If possible, the halfway house should be located in a quiet area of the city, with low overhead a major objective. There should be access to public transportation. A site near an industrial area will assist residents who seek employment.

• Residents should be assigned specific work in helping to establish and maintain their premises.

• During admissions, Mr Carroll said halfway houses must "beware the alcoholic range rider, who has been in every institution from the east to the west coast, and back."

"Don't give up on the so-called failures too quickly, but don't let anyone use your premises as a sanctuary between drinking bouts," he advised.

• "Don't encourage 'bar stool sweeping' or you will be operating an overnight hotel, and your other residents will have to pay for it."

• Insist upon a thorough medical examination for every guest upon admission, and require continued supervision by a doctor during residence. Dental care is another necessity.

"Don't practise medicine by handing out pills — let your doctor handle this. If a resident starts to deteriorate physically, don't hesitate to hospitalize him quickly — he can always return."

• Contact the local police, and explain the halfway house's objectives and proposed methods of operation.

"In case of trouble, let them handle it, and if forcible eviction (this is rare) becomes necessary, let the police do it — that's what they are paid for," he said.

"Don't play with the police. If they are looking for someone, cooperate.

"Don't attempt to operate a security institution. If a resident becomes violent, have him properly removed to some other institution — he may be re-admitted later."

• An absolute rule in a good halfway house is there be no drinking whatever on the premises. Gambling is forbidden also.

• "Don't hesitate to shake down a guest if you think he has a bottle in his luggage. Remember, dog trainers have to be at least as smart as the dog to train him."

• Religious services and outside speakers may be disruptive, and should not be allowed into the halfway house.

• "Don't go into the bail bond business for alcoholics. If they dry out in jail, the house will look good to them when they come out. Don't take more than one or two individuals from an institution at a time, so they don't 'jungle up'."

Scrupulous attention to the business side of a halfway house's operation is as important as therapeutic programming, he said.

• "Don't exploit, or let anyone else exploit, your residents. They are not a free labor force, and if they perform work, see that they get paid.

• "Don't attempt to solve all the sociological and economic distress of the alcoholic. If you solve his alcoholic problem, the rest will clear up in time. Don't expect immediate success — time, patience and perseverence are the basic necessities for success.

• "Don't expect too much public acceptance at first. You are not selling motherhood. Your best advertisement is a corps of individuals who have become reestablished in your community, and who are in a position to aid you and others. Build your own army.

• "Don't enter the field unless you are immune to criticism; disregard any but constructive criticism. The critics don't last long, and generally have no investment in the project."

• Install a pay telephone that will receive incoming calls free, but requires pre-payment for outgoing calls. People in the halfway house who make long distance calls then will have to pay for them.

• "Paint is cheap, and a few hours of painting is good therapy. Don't operate in a dirty, dilapidated atmosphere."

Mr Carroll urged the appointment of a resident manager — "you cannot operate efficiently by remote control. Have him delegate as many functions as possible to guests, so that he will have time for marketing, rest, and recreation. This is a tough job — don't wear him out.

• "Permit no resident to become indispensable. The survival of the house is more important than any resident. Once a management decision is reached, avoid all argument.

• "Be flexible. There are few absolutes in alcoholism, and no rule that can't be stretched a little, except drinking on the premises — don't tolerate it."

He said special attention must be given to former residents after they leave the halfway house.

• "Upon departure, encourage residents to return immediately before they take a drink, if they feel shaky." He said an "alumni association" can help former residents who have problems after discharge.

In heroin addicts

Serum amylase rise may start in lung

LAS VEGAS — The rise in serum amylase after the use of opiates may not be due to a change in pancreatic secretion, Jeffrey J. Heffernon told the 40th annual convention of the American Society of Gastroenterology held here.

In addicts, the hyperamylasemia may have its origin in the lung and be influenced by stress, hypoxia, and even impurities in the heroin itself, said Mr Heffernon of the department of medicine, University of California at Irvine.

He reported on a study of amylase activity in 91 consecutively hospitalized heroin addicts, composed of 78 men and 13 women with a mean age of 25 years.

Total serum amylase activity in the entire group ranged from 10 to 2941 mg glucose/100 ml.

Of the 91 patients, 17 had elevated total serum amylase activity.

Analysis of their sera showed that in 15 the rise was chiefly a result of hypersecretion of salivary-type (S-type) isoamylase.

In one, the rise was due to pancreatic-type (P-type) isoamylase.

In the other addict, equal rises in both S-type and P-type occurred.

"If hyperamylasemia after the use of opiates was due solely to changes in the pancreas, the dominant isoamylase in the serum should be P-type," Mr Heffernon said in an interview.

"Chromatographic isoamylase analysis revealed, however, that in 15 of the 17 heroin addicts with distinct hyperamylasemia, the increased amylase activity reflected mainly a rise in S-type isoamylase.

"It is of interest that 13 of the addicts with hyperamylasemia had acute pulmonary changes."

Twelve had "heroin lung" and one had status asthmaticus.

In these cases, the hyperamylasemia may have been unrelated to drug action on the pancreas and could be due instead to alterations in the lungs.

Hyperamylasemia has been noted in association with pneumonia, asthma, and lung cancer.

In patients with acute respiratory distress, hyperamylasemia may be purely a reflection of the degree of distress they are having, he said.

Other studies have shown that adrenocortical steroids can increase serum amylase activity, but the mechanisms are still unknown.

Another possible explanation for hyperamylasemia in heroin addicts is impurities in the heroin.

Still another factor with pathologic implications is hypoxia due to heroin-induced respiratory depression.

But this factor is difficult to measure.

Coworkers in the study were Drs W. Richard Smith, J. Edward Berk, and Frederick L. Glauser; Louis Friedhandler, PhD; and Katherine A. Montgomery.

Russians brew for Olympics

By John Dornberg

MUNICH — As part of its campaign to wean Russians away from vodka, the Soviet Union now intends to increase its annual beer brewing capacity by as much as 1.5 billion gallons in the next 15 years.

The Soviet Food Ministry's central administration for the beer and soft drinks industry plans to build 20 large breweries by 1990.

Five of the new breweries will have an annual output of more than 100 million gallons, five will be in the 80 million gallon category and 10 others are to have a yearly output of about 50 million.

The first 100 million gallon installation is to be built near Moscow during the current (1976-1980) five-year-plan period and Soviet authorities expect it to be ready in time for the 1980 Olympic Games. Negotiations to build the brewery — a turn-key plant — are currently under way with French, West German, and Italian concerns. Total cost of the installation is expected to be more than $100 million.

The plan for the other large breweries calls for their location in or near major industrial centres, with the distribution radius of each not expected to exceed 200 miles.

Soviet planners have recognized for some time that one solution to the nation's enormous alcohol problem is to offer palatable beverages that are less harmful than highly potent vodka.

The feeling of Soviet experts is that if there were more and better wines, beers, and soft drinks available, people would consume them instead of distilled spirits.

Soviet beers, with the exception of those brewed in the Baltic republics of Latvia and Lithuania with their centuries-long Germanic tradition, are noticeably inferior, not to mention that the supply is limited and distribution is haphazard.

A hint at the problem was disclosed recently by the weekly *Literaturnaya Gazeta*.

Rand Report

Publicity is gravely misleading: NCA

(From page 1)

caution in interpreting the Rand results.

"In my experimental attempts to inculcate controlled drinking in alcoholics, the results looked promising in the first 12 to 18 months. It was only when we did a long-term follow up, ranging from 27 to 55 months since treatment ended, that we detected a universal failure to maintain controlled drinking."

Dr David Pittman of St. Louis, co-founder of the first detoxification centre for public inebriates in the United States, joined the chorus of criticism claiming that a high follow-up interview rate is "an absolute necessity" in interpreting such long term data.

"We feel considerable scepticism should be attached to any follow-up study with a retrieval rate of less than 90%."

The wide publicity given the most dramatic elements of the Rand report could cause serious harm to many recovering alcoholics, says the NCA.

At a Washington DC news conference, held in July by the NCA to publicly challenge the scientific basis of the report, Dr Luther A Cloud, vice-chairman of the Board of Directors of the NCA said: "We are compelled to respond to the Rand report at the public level because of our grave concern that the misleading publicity by this study could hate tragic consequences."

The American Federation of Labor and Congress of Industrial Organizations has issued its own release to its affiliates claiming: "Until there is an insulin-type treatment as in diabetes, or a Salk-type vaccine as in poliomyelitis, or something more conclusive than the Rand study, the bottle is not the answer for alcoholics."

US media persistence in trying to justify the controlled drinking concept reached into Canada when a study by researchers at the Addiction Research Foundation of Ontario (Schmidt and Popham) was cited by wire services as endorsing the controlled drinking concept.

Although only recently published, the study quoted was seven years old and its conclusions provided little or no support for the controlled drinking option in the treatment of alcoholism.

The Journal of the American Medical Association has also joined the fray, declaring in its August 16 issue that alcoholics should NOT try to resume moderate drinking.

The editorial, written by Dr Vernelle Fox, of Alcoholism Services, Long Beach, California, says that "it is very unsafe to advocate any treatment goal except abstinence".

"Someday we may be able to make sufficiently accurate differential diagnosis in alcoholism to allow for different treatment goals — one of which could conceivably be controlled drinking for appropriately-selected patients — but we are certainly not there yet."

David Pittman
'Considerable scepticism should be attached to any follow-up study with a retrieval rate of less than 90%.

Vernelle Fox
'It is very unsafe to advocate any treatment goal except abstinence.'

21st International Congress of Psychology and 10th International Psychotherapy Congress
Paris, France

Drinking drivers see the tree — but still crash into forest

A STUDY of simulated driving under the influence of alcohol has shown that drivers spend longer periods of time with their eyes fixed on an object and as a consequence examine fewer events or the same event fewer times.

Herbert Moskowitz reported this is probably a consequence of the decreased information processing rate under alcohol. In order to extract the same amount of information from an object, the driver has to stare at it for a longer period of time, said Dr Moskowitz, of the department of psychology, University of California, Los Angeles.

"A major factor underlying the increased accident potential of alcohol use while driving is the impairment of visual search behavior as reflected in the increased time necessary for information extraction in dwells and pursuits," he said.

He said the study was undertaken because on-site investigations of alcohol-related automobile accidents have frequently revealed that the immediate cause is a perceptual error.

"The person has either failed to see, or has seen lights, which has been an important contributory cause to the accident," he said.

For the study, subjects were placed in the front seats of an automobile and shown films made along a strip of highway in Venice, California, an urban area with moderate to heavy traffic density.

Subjects wore spectacle frames that contained a device to measure eye movements, and a motorcycle helmet, attached to an apparatus which enabled head movements to be measured while permitting free head rotation and translation.

The 27 men were divided into three groups, of which one was given orange juice with a teaspoon of vodka floating on top; another vodka and orange juice at 0.735 grams per alcohol per kilogram bodyweight over one hour; and the third, orange juice and vodka that administered 1.37 grams alcohol per kilogram bodyweight over 105 minutes.

This produced peak blood alcohol concentrations of 0.0%, 0.075%, and 0.15%, respectively.

Dr Moskowitz said the subjects were all heavy drinkers who had developed considerable tolerance to the effects of alcohol.

"Social or moderate drinkers would be affected to a far greater extent at equal blood alcohol concentrations," he said.

When the allocation of viewing time of the three groups was studied, the alcohol treatment groups were found to show a small trend towards decreased total time in dwells and saccades, but increased total time in pursuits.

In contrast, there were many large changes in the frequencies and mean durations of dwells and pursuits.

"The most important finding," said Dr Moskowitz, "was a large and statistically significant (P equals .004) increase in the average dwell time from 0.37 seconds to 0.47 and 0.48 seconds respectively, for the low and high alcohol dose treatments.

"Given the relatively constant total time in dwell and the greatly increased duration of dwells, the frequency of dwells decreased sharply (P equals .004). This decrease in the number of fixations or dwells under alcohol would reduce the driver's ability to search the environment for potential dangers."

There was also an increase in both the frequency of pursuits and the mean duration of pursuits, "further limiting the opportunity for sharing attention between different events".

In addition, drivers under the influence saw fewer "critical events" in the film that experienced traffic researchers had agreed alert drivers should observe.

The placebo group saw 77% of these events, the low alcohol group 73%, and the high dose group 72%.

There was also a tendency to increased frequency and duration of pursuits on all categories of critical events under alcohol, "although the increase was statistically significant only for pursuit durations on vehicles, turn signals, and traffic lights, not on pedestrians or bicycles."

In other words, said Dr Moskowitz, with a decreased ability to search the environment, the driver preferentially sees what is necessary to his own self-preservation.

Psychopharmacologists

Five steps to improvement

THERE IS a remarkable lack of systematic methodology in most psychopharmacological experiments although they are frequently performed in healthy volunteers and have become an independent discipline, reported Karl Taeuber.

"Rather than developing their own methodological concepts tailored to suit their specific problem, psychopharmacologists tend to adopt methods and techniques from other scientific fields for the sake of convenience or fashion," he said.

Dr Taeuber, of Hoechst AG, Frankfurt, Germany, said a computer search of relevant publications yielded approximately 1,500 papers from 1973-75.

A few of the studies attempted to predict the therapeutic activity of new drugs, a large number assessed more or less specific behavioral effects of established psychotropic drugs, and numerous others investigated the psychotropic effects of non-psychotropic drugs, such as analgesics, either alone or in combination with other agents, such as alcohol.

"The vast majority, however, of the papers we have reviewed reported the effects of drugs with abuse-potential such as cannabis, amphetamines, and alcohol," he said.

Dr Taeuber suggested five ways studies in this field might be improved.

First, psychopharmacological experiments should always start with clearly defined objectives, and every trial should state what role it is supposed to play in the development of theory in its respective field.

While valuable studies on the effects of marijuana, set up with clear hypotheses and objectives, do exist, he said, "there is a vast number of other trials on the effects of cannabis on various memory functions".

"Without clarifying the relevance of such investigations, their only contribution to our knowledge is the consolation that repetitive work, happily, yields the same results again and again.

"Our present knowledge in psychopharmacology looks like a mosaic that does not make a picture," he said.

"Few attempts have been made to develop an integrative theory to explain the relationships between drug action in healthy volunteers and various other therapeutic or addictive drug effects."

Secondly, Dr. Taeuber said more care should be taken in selecting independent variables.

"The usual approach using the drug(s) as independent and the subject's response as dependent variables is but one of many possibilities," he said.

Rather than using drug dosage, one might use blood levels, he suggested.

"While for alcohol this is a common procedure, investigators of other psychotropic agents rarely carry out blood level assessments of the drugs."

While analytical procedures for the estimation of blood levels for most psychotropic drugs are complicated, and often unreliable, "modern techniques like the radioimmunoassay will allow for rapid, specific, sensitive, and reliable estimations of blood levels, and the latter should be taken as independent variables rather than the dose administered."

Dr Taeuber also suggested multivariate approaches be used, taking into account not only drug levels but psychologic characteristics of the population studied.

Thirdly, the investigative team must decide what it is *going* to measure, which is not necessarily what it is really *interested* in measuring.

"Whereas performance is definitely not one of the central problems in most psychic disorders, drug influence on performance is the most widely studied kind of drug effect."

He said more attempts should be made to measure parameters such as subjective mood state, cognitive functions, social behavior, level of arousal, and anxiety.

Psychological assessment should also be supplemented with neurophysiological and biochemical measures, he said.

Fourthly, said Dr Taeuber, the use of healthy volunteers as models for drug action in mental patients, addicts, or drug abusers, is not necessarily adequate. This difficulty can be partially overcome by careful documentation of the characteristics of the "healthy" volunteers, he said.

He suggested that more attention be paid to the concept of "symptomatic volunteers."

Finally, he acknowledged the difficulty in compromising between a large and statistically ideal sample size, and the feasible and justifiable smaller sample size.

"The ethical issue versus the scientific information to be gained from a sophisticated trial should be well balanced," Dr. Taeuber concluded.

His co-workers were Drs. Gert Gammel, Alan Gordon, and Detlev Koeppen.

Psychotherapy should start before detoxification does

PSYCHOTHERAPY OF the drug addict should start before, not after, detoxification, A. J. Charles-Nicolas of Paris's Marmottan Center said here.

Dr Charles-Nicolas, who spoke from the audience during a session of the concurrent 10th International Psychotherapy Congress, said that they had recently begun this approach at Marmottan because it worked better.

"Detoxification is started once the addict begins to understand the therapist, and vice-versa," Dr Charles-Nicolas told The Journal.

"We have the impression that there is a certain moment at which the time is ripe for detoxification."

Dr Charles-Nicolas said that at the beginning of psychotherapy, the addict makes little effort to attend regularly, or to keep appointments. As the therapy progresses, however, the addict begins to structure the relationship, attending more regularly and at definite times.

The relationship may end quite abruptly, with the addict himself deciding after several years of therapy to stop coming, "rather like the ultimate step in his structuring of the therapy."

He also emphasized that the therapist working with addicts must make a special effort to prevent the addict from encroaching too much upon the therapist's private life.

Alcohol / marijuana -- same target but different results

PERFORMANCE IMPAIRMENTS caused by alcohol and marijuana are probably due to deficits in central processing of information, but the ways in which the two drugs affect such processing are probably different, Marcelline Burns of the University of California at Los Angeles said here.

Dr Burns said most studies on the effects of these drugs on peripheral processes, such as sensory function, have shown little or no impairment, indicating a central mechanism.

For alcohol, she said, it has been established that a major source of the performance deficit is a slowing of central processes.

"In general, the findings show that processing is impaired by alcohol under heavy information load . . . under conditions which require divisions of attention.

"Performance can be maintained under conditions of low information as for a concentrated attention task with a single source of sensory input," she said.

By contrast, marijuana adversely affects performance under both concentrated and divided attention conditions, and the deficit does not appear to be contingent upon a condition of heavy demands for information processing.

Rather, the evidence suggests that marijuana induces a shift of attention away from external events and heightens responsiveness to internal events, she said.

"This intermittency of attention appears to underlie the performance deficit," she said, noting evidence that the marijuana-intoxicated individual can temporarily turn off the "high" and direct increased attention to external stimuli briefly.

"The lapses are subject to some voluntary control, but as demonstrated in the laboratory, it is short-lived. There are no data as to whether an emergency or stress situation with high information processing demands can prolong the increase in attention."

Journal correspondent Lynn Payer reports

Withdrawal by acupuncture for 600 Hong Kong addicts

QUEBEC CITY–A Hong Kong study that combined acupuncture with electrical stimulation has successfully treated all 600 research subjects for narcotic withdrawal symptoms.

"Further, there is no risk of the patient becoming addicted to another drug, such as occurs in the substitution technique of drug addiction treatment," Hsiang Lai Wen told a meeting of the Collegium Internationale Neuro-Psychopharmacologicum held in Quebec City.

"The treatment itself is very easy to carry out and with no overt side effects. It is economical and can easily be done on an out-patient basis. It can also be applied to all drug withdrawal patients," said Dr Wen.

For these reasons Dr Wen, a Kowloon brain surgeon associated with Kwong Wah Hospital and the Tung Wah group of hospitals (Kowloon), said he hoped acupuncture — along with electrical stimulation — would be a mode of treatment of withdrawal symptoms in the future.

In the 600 subjects addicted to either opium or heroin, it was found that by subcutaneous application of needles on each side of the ear (at the concha) with the needle electrically stimulated to a frequency of 125 Hertz and with current averaging 5-6 volts, withdrawal symptoms could be effectively treated.

"The average duration of treatment was 7 days. It was found that the withdrawal symptomatology gradually disappeared after 10 to 15 minutes of treatment. The average treatment lasted one-half hour although some patients needed two to three sessions per day."

Following hospital treatment for withdrawal, the patients were transferred to rehabilitation units, but while still in hospital, Dr Wen reported they became more interested in their environment, more talkative, and more mindful of general appearance.

"Psychologists and sociologists also found them more receptive to counselling during and after treatment."

There was one unexplained finding. Biochemical studies revealed a decrease in the subjects' cyclic AMP as well as lower cortisone and ACTH levels. Dr Wen told **The Journal** he has no idea why these changes occurred (found early on in each case) or their meaning.

Although he presented a theory of the possible therapeutic action of this treatment, he agreed that acupuncturė remains empirical. He suggested further investigative work.

Alcoholic crisis times predictable

EDMONTON — Recovery from alcoholism or other chemical abuse takes much longer than is commonly realized, a conference of alcoholism workers has been told here.

Diane Fontaine, project director for an association of halfway house alcoholism programs in St. Paul, Minnesota, said recovery programs with the greatest success records are those which recognize that at least two or three chemical-free years are required as a minimum for a patient to begin a new kind of life style.

The best programs also are based upon recognition that "recovery involves the whole person — the physical being, the psychological-emotional being, and the spiritual being," Ms Fontaine said.

"A multi-disciplined approach is essential in the recovery process, a process which involves every community in a continuum of health care services. Every recovering person should have the benefit of a therapeutic community team approach."

She said halfway houses should expect recovering alcoholics to have predictable times of personal crisis — at five to seven weeks after the last drink, at five to seven months, at 11 to 13 months, and at 18 months.

This information, endorsed by groups such as Alcoholics Anonymous, helps the patient to understand what is happening, and helps fellow residents and therapists to adopt a tolerant and supportive attitude which reinforces desirable behavior, she said.

Many recovery failures can be traced to a policy of discharging patients just in time for one of the predictable "crisis periods".

Magnesium a link in alcoholic death?

MONTREAL — The possibility of sudden death in alcoholics from serious heart fibrillation as a result of magnesium deficiency was raised here at the Second International Symposium on Magnesium.

Excretion of magnesium used by the body's nervous system and vital to muscle function is greatly increased by alcoholism. According to Lloyd T. Iseri, professor of medicine, University of California, Irvine College of Medicine, magnesium depletion may be a hidden factor where premature heart beats, tachycardia, and fibrillation occur in the acute alcoholic.

The specific cases reported by Dr Iseri dealt with alcohol addiction withdrawal symptoms. The heart arrhythmia in the first case was life-threatening and, in the second, potentially life-threatening. In neither case was lidocaine effective in controlling the rhythm.

The first case, a 54-year-old female, had a history of heart disease. In the emergency room, she was agitated, tremulous, and disoriented, and developed fibrillation that could not be controlled by large doses of lidocaine.

Blood serum magnesium was obtained and 20% magnesium was infused over a one-minute period. This was followed by 500 cc's of 2% magnesium sulfate over four hours. The treatment completely prevented recurrence of the fibrillation. She remained off alcohol and was relatively well.

Another case of alcohol withdrawal concerned a 56-year-old man who had been drinking heavily for a week prior to admission. He was given large doses of diuretic and digitalis preparations and developed intractable multifocal and multidirectional tachycardia. Magnesium was given with immediate normalization of rhythm.

Although in the first case, the digoxin level was well below the accepted toxic level, Dr Iseri said the second case was one of digitoxicity associated with magnesium depletion (1.21 mEq/L).

"Susceptibility to digitoxicity may have been augmented by the magnesium deficiency."

In addition to alcoholism, Dr Iseri and co-worker Dr Alan R. Bures listed other clinical disorders that may result in magnesium depletion. They included cirrhosis, pancreatitis, and malabsorptive states.

"We should anticipate the possibility of syndromes associated with magnesium depletion so we can prevent preventable deaths not only in hospitalized patients but in non-hospitalized patients before they get there."

A drastic turn of events in these disorders, he said, may be sudden and unexplainable.

Student drug use study

Deviance and conformity influenced by peers

By Thomas Hill

MIAMI, Fla. — How much influence do parents have on drug use by high school students?

Seeking answers to this and other questions about teenage alcohol and drug abuse, two researchers from the division of addiction sciences at University of Miami Medical School did a study among more than 2000 students in a large Miami area high school.

Dale D. Chitwood and Duane C. McBride found that both the attitude and the example of parents play a significant role in influencing the drug use behavior of high school students. But, the attitude of peers carries greater weight with most teenagers, as some other studies have shown.

Dale Chitwood

Of students whose mothers tolerated drug use, the investigators found, 64.7% used marijuana, pills, or opiates. Of those whose mothers discouraged drug use, only 32.6% used marijuana, pills, or opiates.

The attitude of the father had almost equal weight if fathers tolerated drug use, 65.3% of their student offspring used them, but discouragement of drug use by the father reduced this to 32.4%.

When high school students' friends encouraged or approved of drug use, 73.3% used drugs. When friends disapproved, only 26.6% reported using drugs. (Alcohol was not considered here).

It has been known for some time that friends of highschool students may have a strong influence toward deviant behavior. This study appears to show, however, that friends may also exert a strong influence toward conforming behavior.

The team also explored whether and to what extent a teenager's drug use behavior is influenced by parental use of "legitimate drugs", ie. over-the-counter or prescription medications.

Of those whose mothers used legitimate drugs many times or every day, 59.4% used marijuana, pills, or opiates. When mothers never used drugs, only 31.2% of the sons or daughters were drug abusers. When the fathers' use of legitimate drugs was considered, the comparable figures were 63.2% and 32.0%.

Asked if they felt they were under pressure to use alcohol and drugs, almost two-thirds (63.2%) indicated little or no pressure to use alcohol, and a slightly smaller number (60.1%) perceived little or no pressure to use drugs.

One reason the majority felt no pressure to use alcohol or drugs, the researchers suggested, was that they didn't perceive such use as contributing to popularity. When asked if they believed alcohol or drug users to be more popular than non-users, 70% of students did not regard users as more popular.

Other figures that emerged from the study were:

- About half of the student body reported they did not now use alcohol or drugs.
- Approximately 25% reported using alcohol but not drugs, and 25% reported using drugs (which in some cases included alcohol). Only 1.4% admitted to current use of opiates.
- The percentage of substance users tended to increase with advancement through high school. More than 42% of the sophmore class had never used drugs or alcohol; the percentage declined to about 32% in the junior year and 28.5% in the senior year.
- In general, students considered that very little drug and alcohol use occurred in regular school hours. The only exception was found among opiate users, of whom 62.2% reported that use occurs in school.
- Most students (86.4%) believed drug and alcohol use did not occur at school athletic events.
- A majority (71.6%) did not believe alcohol and drug use occurred at school dances.
- Nearly two of three students reported that most alcohol and drug use takes place in the school parking lot (presumably before and after school, or in free periods). This led the investigators to suggest that any program designed to reduce drug abuse at school "should include a strategy for responding to the parking lot situation".

When asked whether they thought an alcohol-drug education program would be useful in their school, 59.4% of students said they felt it would be useful. But when the investigators broke this figure down they found that the students who supported the idea of such a program were, in the main, non-users of drugs and alcohol, whereas a substantial majority of drug users did not favor it.

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Guest Editorial *

CMA edging up on drunk drivers

A JOINT committee of the Canadian Medical Association and the Canadian Bar Association will study the feasibility of making consent to blood analysis a prerequisite for getting or renewing a driver's licence in Canada.

Such legislation has been suggested by the CMA's committee on emergency medicine, as both a way of curbing impaired driving, and of documenting further the involvement of alcohol and other drugs in driving mishaps.

No easy meeting of the minds can be expected between the two professions. Doctors, increasingly concerned with preventive medicine, are understandably appalled at the rate at which they are expected to patch up, or pronounce dead, the victims of the highway carnage that Canadians seem to take for granted.

However, one of the principles of Canadian law is that a person should not be forced to testify against himself, and many lawyers would naturally interpret such legislation as encroaching on this right.

In order to get a driver's licence, the applicant would have to agree in writing that a doctor could take a blood sample to be analyzed for alcohol or other drugs in the event of an accident, or if police attention were drawn to his driving behavior.

As the law stands now, a doctor may take such a sample only if the patient consents. They also need consent to give test results to police.

If the patient is unconscious — not an uncommon situation in car crashes — consent obviously can't be given. The doctor may take a sample for medical purposes knowing a drug level may be important in treatment, but he can't give results to police.

The issue of personal rights is an important one, but in this situation, the rights of a far larger number of citizens are involved. They are the sober pedestrians, cyclists, and motorists who have a right to expect that the driver of an approaching car hasn't had his perception and reflexes bludgeoned with anesthetic.

Provincial governments point out repeatedly that driving is not a right but a privilege. Withholding a licence from someone who refuses to allow a test of how responsibly he exercises that privilege, should not be made a "rights" issue.

Dr William Ghent, chief of surgery, Hotel Dieu Hospital in Kingston, and chairman of the CMA committee that made the recommendation, says breathalyzer tests have not resulted in the hoped-for reduction in impaired driving.

Some researchers have noted that the effectiveness of the breathalyzer program depends on the driver's perceived risk of being caught.

Experience has shown the Canadian driver doesn't see that risk as very high. At the same time, he lives in a society where the culture condones drinking and driving, and the parking lots provided by every drinking establishment encourage it.

Blood tests may not significantly reduce the incidence of drunk driving any more than the breathalyzer has. But they would, as Dr Ghent says, provide an even more complete picture of the role drugs play in accidents. And they might add to the deck of cards stacked against the Yahoos who insist on aiming their cars home from a watering hole.

Those who have a more mature attitude to their driving need all the help they can get.

(Betty Lou Lee, a correspondent for The Journal, is president of the Canadian Science Writers' Association.)

The Journal Letters

The Journal welcomes all Letters to the Editor. We do reserve the right to edit all correspondence, however, every effort will be made to maintain the core of the readers' opinion. Letters bearing the full name and address of sender may be sent care of The Editor, The Journal, 33 Russell St., Toronto, Ontario, Canada, M5S 2S1.

"At least he died happy — last words were,'who said I can't drink and drive'?"

Inside Science

Jury out

By Howard Cappell *

TOLERANCE AND physical dependence are perhaps the most thoroughly studied features of chronic exposure to psychoactive drugs.

Tolerance refers to the observation that a given dose of a drug becomes less potent as a consequence of long term exposure; only by the administration of an increased dose can many effects be reinstated to their previous levels. Although there is considerable doubt and controversy in the case of particular compounds, it seems that tolerance develops to many effects of virtually all drugs abused by man.

Physical dependence refers to a consequence of drug use that becomes evident when the level of administration is severely curtailed or entirely cut off. Symptoms of withdrawal begin to emerge as levels of the drug in the body drop; these symptoms can be very dramatic and aversive, and in some cases, withdrawal, if untreated, can be a threat to life. Usually the most effective means of reversing a withdrawal state is by administration of the drug that caused it in the first place. As with tolerance, physical dependence seems to result from repeated exposure to sufficient levels of virtually all abused psychoactive drugs.

Although we already know a great deal about tolerance and dependence, there is much yet to be learned of the mechanisms underlying these phenomena. Another particular area of our ignorance is the importance of tolerance and dependence in maintaining drug-taking behavior itself.

At first glance, the evidence on tolerance seems compelling. Speed users, for example, dramatically escalate their drug intake to levels that would easily be lethal to naive users. Alcoholics are capable of prodigious feats of drinking that would lay waste to social drinkers.

In short, drug abusers are clearly tolerant to the drugs they imbibe. Yet all we know for certain to date is that tolerance is a consequ exposure — there evidence implicati a cause of escalatec

This issue is of interest. A recent a of the World Healt evidence of tolera marijuana as suppo stone" theory of exotic and potent The reasoning was cause the subjecti ana to pale, thus n more potent chem argument was fla fused tolerance a drug taking with to drug taking.

There is anothe avoided in this relatively easy to d to some effects example, suppose w develops to the m duced by marijuan tolerance develo effects for which

Backgrounder

Heroin/crime link not established fact

By Milan Korcok

K ABOUT the spread of heroin use, he spectre of street crime lurks in ackground.

ver mind that the addict might be nd screwed up. It's his propensity rglarize television sets that makes a social menace. It's his image as t, thief, and pimp that prods the cience of politicians and policy ers.

t, the relationship between crime eroin use is far from being a cut-ried equation.

ny heroin users are not serious nals. And, as researcher Nicholas l of the US National Institute on Abuse recently told a meeting of hiatrists: "The most serious inals in America today are not n users."

s pretty widely accepted that heroin is not criminogenic — that there is harmacological factor in the drug incites violence or encourages pre-ing criminal tendencies.

t there is a lot of evidence that as in use in a community goes up, so the crime rate, and there is a lot of to show that most contemporary rican heroin users have criminal ds.

hich came first, the heroin or the e? Are heroin users criminals who happen to use heroin, or did heroin make criminals of people who other-would not have committed crime?

udies in Washington, DC have n that 53% of adult, male, heroin s and 20% of female heroin users in ment who had criminal records, got before they first used heroin.

her studies have shown that up to of heroin users in large, urban, timodality treatment programs rted no arrests at any time.

appears there are many current in users who do not fit the otype image of criminal heroin s.

t that does not negate the fact that majority of users, involvement in e (over and above the heroin use) is ly decision.

Vernon Patch has reported from on that in 1971, 13% of all robberies, of all burglaries, and 41% of all nies in that city were committed by in users. And Kozel has also rted that about a quarter of all tified serious criminal offenders in or American cities were active in users at the time of their arrest.)

e existence of temporal relation-s between heroin use rates and us property crime have been argued ome time.

ta from Washington, DC and from onal FBI lists show a striking correspondence over time between heroin use rates and crime.

In other American cities the correspondence has not been as precisely replicated. And so the jury is still out.

Not every heroin user commits crimes to support his habit, and many who are not heroin users also commit crimes.

It seems pretty obvious that if any community could eliminate its heroin supply, it could cut into its crime statistics dramatically. But how to do it?

From 1970 to 1973, the Public Research Institute for the US Center for Naval Analyses — an independent research organization located in Arlington, Virginia — studied heroin prices and crime rates in Detroit. The institute released its report in 1975.

What the researchers (Lester Silverman, Nancy Spruill, and Daniel Levine) found, was that those who advocate a tough, unrelenting crackdown on heroin supplies could be burned by a backfire.

Their scenario: as supplies of heroin decrease, prices rise. The higher prices don't drive users out of the market, the users just commit more crime to get more money to obtain the more expensive drug. Conversely, when the price falls, so does the crime rate.

The Silverman report showed that whenever the price of heroin increased 10% in Detroit, revenue raising crimes increased 2.9% citywide — close to 6% among addicts.

At the same time, armed robberies increased 6.4% citywide, unarmed robberies and burglaries 4%.

Significantly, the most frequent victims of the increased crime committed by heroin users were the people of the poor neighborhoods — regardless of whether they were white or black.

This backfire provides a real dilemma for public policy makers because if you can't count on "get tough" laws to cut into heroin-related crime, what can you count on?

Theoretically, if you leave the heroin marketplace alone and allow supplies to increase, then the price should drop and heroin-related crime should decrease. But at the same time, the community would have to anticipate more people trying heroin for the first time and more using it regularly.

There are other options: clean, quick, and hard punishment for heroin-related criminals; decriminalizing the possession and sale of heroin; establishing heroin maintenance programs; focussing enforcement directly on heroin-related offences (rather than indirectly by seeking to control and restrict heroin supply and availability).

But all of these options are studded with thorny political issues that could keep policy makers talking for a long time.

The one option that seems more practicable — except perhaps for fiscal reasons — is to increase addict-treatment availability.

A study by the Center for Naval Analyses estimated that a 19% increase in the number of treatment slots for Detroit would lead to a 2.1% reduction in property crimes.

The same study indicated that the cost of expanding treatment capacity in that city would be less than the value of the property that might be stolen.

Reduced criminality among heroin addicts in treatment has been reported widely (by Dole and Nyswander in New York, Senay and Jaffe in Chicago, Newman in New York, Patch in Boston). And this reduction was not limited to methadone patients.

A study of 38,000 clients in more than 50 federally-funded drug abuse treatment programs between 1970 and 1974 showed that during treatment, there was a reduction of criminality for those in methadone programs of 65%, and for all treatment programs combined of 59%.

Of course much of this crime reduction relates to heroin offences per se, but the trend is clear nonetheless.

"Treatment," says Kozel, "has brought the heroin user out of the shadows and into public view.

"The public has seen that the heroin user often looks a lot more like everyone else than previous terrifying stereotypes led people to expect."

If that is so, then perhaps the "self-perpetuating heroin crime cycle of expectation and behavior" may itself be broken.

Editor ... Letters to the Editor ... Letters

Mom and Dad weren't necessarily right

To the Editor:

First, let me say how much I appreciate **The Journal.** I find it a very informative source of material on drugs and drug abuse.

However, I question the article in the June issue headlined "Mom and Dad were right, drugs up/grades down". It may very well be an accurate statement, however, there is dearth of actual evidence in the article. If this is a fact as presented, that the use of drugs brings school marks down, then I would say it is a major breakthrough in research. However, the correlation could also be between intelligence and drug usage and not school marks and drug usage. Could it not be that a very intelligent person gets high marks and does not use drugs and those with lower intelligence get lower marks and use drugs?

The article appears to take the stand that drug users miss school, suffer suspensions, and are less likely to graduate than non-users of drugs. This is also predictable in people with lower intelligence ratings. Did these longitudinal studies take measures of intelligence before and after the five years? Did intelligence drop? I appreciate the fact it is difficult to conduct a controlled study in this type of research.

Publishing half-truths or possibly non-truths can do nothing but hurt research in the area of drug abuse. I am writing this letter not to be critical but because I feel that if this information is presented to teenagers as fact most of them will say "that doesn't prove a thing". And they would be absolutely right.

T. D. Levasseur
Lieutenant
Base Drug Education Officer
Canadian Forces Base
Portage la Prairie
Southport, Manitoba

Abstinence plan welcomed

To the Editor:

As a devoted subscriber I am grateful for the scope of your reporting. I find your article on contracted abstinence (commendatory of our basic pledge) (**The Journal**, August) particularly rewarding. For in 1960 I warned the Alcoholic Center at Yale University if they continued to advocate that youth who did not want it "should accept a drink but dispose of it surreptitiously," it would only weaken physical and spiritual stamina generally now evident.

Consequently in the effort for a completely fair hearing on an abstinence lifestyle, I hope you will correct the imputation of 'self-righteous and judgemental attitudes by temperance individuals and organizations' that have been mistakenly attributed by those guilty of not using good judgement themselves. I can make this definite statement from personal observation during a lifetime of preferred abstinence, similarly preferred by our distinguished United States Senator Strom Thurmond.

Since my grandmother was a charter member of our organization in 1874, I also know the attitude from the inside, which is heartfelt concern to save individuals from mental, moral, and physical deterioration (Rom. 12:2-KJV). When the ultimate cure for alcoholism is abstinence — the Rand Study notwithstanding — due to the action of alcohol in the bloodstream, your closing comment: "Such a step need not wait for further research or organizational development" is indeed welcome.

Marion B. S. Crymes
Representative
National Bureau of Legislation
Woman's Christian Temperance Union
Pennsylvania Building
Washington DC 20004

International efforts

To the Editor:

The office of the Commissioner for Narcotics, Hong Kong Government, has been a subscriber of **The Journal** for a number of years and we have found your publication most informative and useful in our anti-narcotics efforts here in Hong Kong.

The complicated problem of drug abuse cannot be solved by the efforts of one particular country or territory alone.

International cooperation has been recognized as an essential factor in our work. It is to publications like **The Journal** that we turn for the latest information regarding what happens in the various fields of anti-narcotics work throughout the world.

Rafael S.Y. Hui
Assistant Secretary for Security
Narcotics Division
Security Branch
Colonial Secretariat
Hong Kong

on tolerance/dependence

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although this error of inference is often committed. In fact, the only direct test concerning tolerance and marijuana use suggests that relatively heavy users really require no more marijuana to achieve a desirable effect than do infrequent users.

Physical dependence seems like a powerful motivation for continuing drug use. Few investigators doubt that it makes some contribution, but it is clearly not enough by itself. The most thorough data available are from human and animal studies of alcohol dependence. Monkeys, for example, can be induced to self-administer alcohol to the point that they become physically dependent upon it. Yet for reasons unknown, they will at times stop taking the drug and endure a severe bout of withdrawal — even though alcohol remains freely available, and even though taking it would reverse the withdrawal state.

A very similar phenomenon has been observed in laboratory studies of chronic drinking in alcoholics. During experimental drinking sprees, alcoholics have often been observed to enter at least a partial withdrawal phase, apparently voluntarily, even when their supply of alcohol remained ample. Apparently, physical dependence is not the demonic force in maintaining drug-taking behavior that popular descriptions often paint it to be.

Tolerance and dependence are concepts that are used liberally and often carelessly in accounting for drug-taking behavior, Yet the evidence is far from conclusive about their precise role.

*** Dr Cappell is head of psychology and psychological studies (Research Division and Clinical Institute) of the Addiction Research Foundation of Ontario.**

Analgesics, including the traditional home headache remedy ASA, account for two-thirds of emergency hospital admissions in four US cities, according to a series of recent studies by the University of Miami's Division of Addiction Sciences.

Main OTC problem is ASA

MIAMI — The over-the-counter medication most frequently involved in adverse reactions serious enough to warrant emergency hospital admission is that old reliable headache remedy and physician's friend, acetylsalicylic acid (ASA).

The conclusion is based on a series of studies by the Division of Addiction Sciences of the University of Miami's department of psychiatry. It has been found that analgesics (pain relieving drugs) account for approximately two-thirds of emergency room admissions. Of the analgesics, ASA (Aspirin) represents about two thirds.

Dr James A. Inciardi, director of the large four city collaborative project (Houston, Denver and New York, in addition to Miami) that has grown out of the division's studies of emergency room admissions relating to drug problems, explains this finding by noting that particles of ASA often irritate the mucosa of the stomach. "Each aspirin dosage causes a small intestinal blood loss."

Placing the figures in context, Dr Inciardi notes that during a recent 18-month period, 3,400 drug-related cases were treated in the emergency room of Miami's 1,300-bed Jackson Memorial Hospital. Of these, 249 cases (7.3%) involved over-the-counter drugs.

Analgesics and sedatives together accounted for 83% of such cases. Analgesics alone accounted for 165 cases (66.3% of the 249) and ASA was involved in 110 of these.

People admitted for reactions to over-the-counter (OTC) sedatives numbered 42. The majority of these involved drugs containing the belladona alkaloids. Sominex accounted for more than three-fourths of the acute adverse reactions.

Classifying the emergency room patients by sex and age, Dr Inciardi found that 77.6% of those with adverse reactions to analgesics were female and 81.8% were between 14 and 34 years of age. Of those admitted for OTC sedative overdose, 62% were female and 76.2% were in the 14-34 year age group.

Analyzing mass media advertising of drugs, Dr Inciardi notes it is directed primarily toward women and focuses heavily on analgesics.

He suggests usage patterns "are dictated not only on the basis of individual need, but also by the subliminal influences of mass media promotion".

Another phase of the emergency room study, conducted by Dr Robert S. Weppner, Karen S. Wells, Duane C. McBride and Dr Robert A. Ladner, has produced much new information about the abuse of prescription drugs and illicit drugs.

Contrasting usage practices of emergency room patients with those of people in treatment programs, the investigators found that people who came to the emergency room of Jackson Memorial Hospital because of acute drug reactions tended to be female and predominantly abusers of prescription drugs. People in treatment programs were predominantly male and primarily abusers of illicit non-prescription drugs.

In school curricula

Ireland launches drug program

DUBLIN — Ireland's infant national Health Education Bureau has embarked on an ambitious long-term program to incorporate drug education in school curricula throughout the country.

The idea is that the subject should not be singled out — instead, it is to be embedded in the curricula and dealt with in relation to other problems of growing up and exercising responsibility.

Established in February, 1976, the bureau has been running a pilot project to bring its national approach to post-primary education into focus.

Schools in a built-up suburban area in North Eastern Dublin City and in the medium-sized provincial town of Monaghan were selected for the project. The classroom emphasis is on the growth and development of young people with special attention paid to the pressures and problems of adolescence.

"We hope," explains a spokesman for the bureau, "that from this project will emerge the guidelines for training teachers in health education in the context of a national health education program for post-primary schools."

The bureau was established to advise the minister of health on aspects of health education which should have priority at national level. Its first chairman is Bunny Carr who was chairman also of the Committee on Drug Education whose report laid the foundation for the bureau.

The committee had observed in its report that responsibility over health education had been fragmented under the authority of a variety of statutory and voluntary organizations; and it recommended the establishment of a single body for the purpose "as a matter of urgency to supply the needs of health education and to co-ordinate the existing efforts".

Europeans thirstiest

LONDON — Thirsty Europeans drink half of the whole world's production of alcohol. Yet the 455 million people in Europe make up only 13% of the world's population. And even within the continent itself, there are enormous variations in individual countries' drinking habits. Icelanders drink only three litres of absolute alcohol a year while the French manage 17 litres each.

Sensory deprivation

'It' might be used in other addictions

(From page 16)

extended reflection, or the creation of a break in the smoker's life, which allows him to start on a new tack.

Whatever the explanation, it seems to work.

Dr Suedfeld's observation, in the original experiment, that many people, although they did not quit, drastically reduced their cigarette consumption, raises the possibility of "controlled smoking".

Dr Best said he is planning an experiment to see if permanent reductions in smoking level can be obtained through sensory deprivation. Another future line will be to try to develop "minimal therapist" treatment packages for remote communities without the resources of a major university.

The sensory deprivation apparatus itself, says Dr Suedfeld, is relatively simple and inexpensive — all that's required is a light-tight, ventilated room, lined with sound-absorbing and sound-excluding material — even egg cartons will do in a pinch.

Given the chamber, the technique is economical in terms of both the therapist's and the patient's time, as it appears only a single session is needed for long term effects.

Dr Best has already begun to "export" his satiation smoking approach by training people to run the program in a local health centre. He hopes eventually to disseminate it to doctors, public health nurses, and other health professionals.

Dr Suedfeld, with two other psychologists, is planning to set up a quit smoking clinic in which the sensory deprivation technique will be applied.

The potential of sensory deprivation as a clinical technique is beginning to be tapped — the successful treatment of snake phobic and obesity at UBC are ready second examples. An exciting possibility is the use of the sensory deprivation chamber in treating other, perhaps more debilitating addictions.

Peter Suedfeld

Controlled smoking with sensory deprivation therapy?

COLLISION COURSE

AWARD WINNER!
"Best of Audiovisual Media Festival"
– BIOCOMMUNICATIONS'76

Content and Purpose

"Collision Course" is a dramatic essay which explores the potentially tragic consequences of mixing even moderate amounts of alcohol with the complex task of driving.

It is designed to impress upon the viewer that one is at risk even when generally socially-acceptable drinking behavior is practised.

The viewer is introduced to a young middle-class couple and their parents. The film follows the young couple's activities throughout the evening; taking in a movie and having a few beers with friends. At the same time, their parents are discussing some known facts relating to problems contributing to the carnage on the roads. Also introduced is a blue collar worker who, after a tiring day on the job and a couple of after-work drinks, takes to the highway.

The film dramatically analyzes the behavior of the indviduals involved and their subsequent actions.

As the audience is geared to suspect from the first, the young couple and the blue collar worker eventually meet . . . in the middle of the night on a lonely road.

Audience and Use

Collision Course is an action film which is ideal for use with a variety of audiences (e.g. driver education programs, driver training courses, home and school associations, student groups, community action groups). Community workers in the alcohol and drug dependency field will find this film a valuable teaching aid in the exploration of legal, social and behavioral aspects of drinking-driving issues.

Order Form:

Forward order to:
Addiction Research Foundation,
% Marketing Services
33 Russell Street,
Toronto, Ontario
M5S 2S1

This film will not be available until May 7, 1976

☐ More Information ☐ Purchase . . . $325.00 ☐ Preview . . . $35.00
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Name: _____

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16mm, color film , 17 minutes

Sober alcoholics are slowed

WELLINGTON, NZ — Even when a chronic alcoholic is cold sober, he is less efficient than other people in performing some of the tasks involved in driving a car, a New Zealand psychologist told a road safety research seminar.

But, said Robert A. M. Gregson, professor of psychology at the University of Canterbury, the sort of behavior measurement which uses breath samples, observation of swaying gait and slurred speech, and inability to converge in focusing vision is not remotely relevant in studying the alcoholic's cognitive impairment.

He said a driver must pay selective attention to a stream of signals feeding into his eyes, ears, body senses of position and motion, and the other senses. These signals, or situations, must be recognized, decoded, used as the bases for decisions, and stored or dropped rapidly in order to process the next signals which come along.

Though Dr Gregson rejected the notion that a chronic alcoholic when sober behaves as everybody else does when drunk, he said the acute alcoholic functions inefficiently, both as an information input channel from the world to his central processes and as a decision-maker.

He slows up in his decision making — though not necessarily in his road speed — and loses bits of input in a quasi-random fashion. His motor skill output shows a fair number of errors and over-corrections.

"All this ensures that sooner or later, even on a road which has a low cognitive load at 80 kilometers an hour, he is mentally overloaded and so wraps himself around a power pole or a passing pedestrian," Dr Gregson said.

The chronic alcoholic shows impairment of his short-term memory, particularly for material which is novel to him in content and structure — a defect "which the unpaced pencil and paper type tests were not designed to pick up".

Dr Gregon said the alcoholic cannot compensate by slowing down and taking things steadily.

"Apart from the fact that you don't have the option, obviously, of doing this in rush-hour traffic, it doesn't work for the chronic alcoholic although he may want to believe it does. He . . . has both diminished memory and a lowered capacity to organize past information he has received, and his response rate becomes progressively slowed as the task complexity increases, slower even than the corresponding rates in normals, if he chooses to do the task at all."

Kiwis drinking smoking more

AUCKLAND, NZ — New Zealanders are drinking and smoking more, according to the latest official statistics.

Consumption of beer rose from 126.1 litres a head in 1974 to 133.1 litres last year. Spirit drinking increased from 2.9 litres to 3.0 litres. As for wine, the statistical New Zealander downed 9 litres of wine in 1974. Last year's figure is not yet available.)

Tobacco consumption rose from 2.4 kilograms a head in 1974 to 2.5 kilograms in 1975.

Harsh blows

Eighty lashes for drinking alcohol, and a hand chopped off for theft, are two of the penalties proposed in a draft law approved by the Egyptian People's Assembly. The law would subject anyone caught selling, making, or drinking alcohol — whether Moslem or not — to between 50 and 80 lashes. 'Severe' penalties, however, are reserved for adulterers who may be sentenced to death by stoning. Mere fornication could net the unfortunate 100 lashes.

Whisky a day

A 14-year-old Australian boy died, allegedly of alcohol poisoning, after having consumed a bottle of whisky a day since he was 10. Other statistics which indicate Australian adolescents' preoccupation with liquor, published by the National Youth Council, state that four of 10 people, aged 12 to 20, often become drunk, and 13% of Melbourne's high school students drink more than 10 beers a day.

In hospital

More than a third of the men admitted to Scotland's mental hospitals and psychiatric units in 1974 were suffering from alcoholism, or alcoholic psychosis.

Bales of ale

Britons drank a record amount of West German beer in 1975 — 38.5% more than the previous year's figure. West Germany is the third largest exporter of beer to the United Kingdom after the Irish Republic and Denmark.

Throat cancer

The high rate of throat cancer in Northern France has been linked with alcohol. Most of the instances of throat cancer in Britanny, researched by the International Agency for Research on Cancer, turned out to be in heavy drinkers.

British start program

Special volunteers will help women alcoholics

LONDON — The rapid increase in drinking by British women and the relatively short period it takes them to become alcoholics have persuaded specialists to introduce a special course for volunteers to aid alcoholics as well as their families.

Alastair Mackie, director-general of Britain's Health Education Council, says it may take only three years for a woman to become an alcoholic.

"The qualifying period for alcoholics — that is to say the years before total dependence takes over — is much shorter for a woman than for a man," he told the National Council of Women at a London conference. "It is, in fact, three to six years for women, compared with eight to 12 years for men."

The ratio of female to male alcoholics has been steadily rising, he said. Of every three alcoholics in Britain, one is now a woman. Treatment for women is more difficult, he went on, because, aware of society's condemnation, they tend to contrive to conceal their plight until they are beyond effective help. The effect on the family is disastrous.

The scheme to train volunteer counsellors to help alcoholics as well as their families is being organized jointly by the National Council on Alcoholism and the Alcohol Education Centre here.

Turkish opium plan a success: UN

By Thomas Land

GENEVA — A top United Nations supervisory team has returned from Ankara satisfied that the illicit trade in Turkish heroin, which once flooded the rich and desperate backstreet markets of North America and Western Europe, has now been brought under control despite the commercially successful resumption of opium poppy cultivation in Central Anatolia and six other provinces.

Turkish poppy growers are now gathering their second harvest after a short-lived total ban on the crop imposed in 1972 by an interim military government under intense American pressure.

Their first harvest, supplying the expanding world pharmaceutical industry, yielded well over $40m in domestic revenue and hard foreign exchange, compared to $35m offered by the United States to finance the entrie crop substitution program. In addition, the country has received about $4m in international technical assistance to ensure that narcotics smugglers are kept away from the poppy fields.

Professor Paul Reuter, chief of the UN's International Narcotics Board, and Gilbertus de Beus, of the UN Fund for Drug Abuse Control, believe after exhaustive investigations on the spot, that the world is now safe from illegal Turkish opium.

They consider the chief danger generated by the success of the Turkish experiment is not so much a resumption of illegal trafficking from that country as the temptation to other governments to legalize poppy cultivation without the ability to exclude the traffickers.

A kilo of pure heroin, converted relatively easily from opium, fetches over $50,000 wholesale in New York, Vancouver, London, and Amsterdam. Narcotics specialists argue that many traditional poppy growing countries simply lack the organization and industrial facilities to keep away sophisticated traffickers attracted by such financial rewards.

The Turks have adopted the straw process of harvesting used successfully, although on a smaller scale, in the Soviet Union and Poland. Traditionally, the peasants cut the poppy pods to extract the opium gum; now they are forbidden to handle the pods, and sell the entire plant to a state monopoly organization for industrial processing. Cultivation is under licence and close supervision.

"Our conclusion is that the system definitely works," says De Beus.

Their verdict is supported by the narcotics law enforcement agencies in many countries which have recently evolved methods of chemical analysis to trace the geographical origin and age of seized heroin.

The Turkish produce, which once flooded Westwards via Marseilles through the clandestine laboratories of the notorious "French Connection", has virtually disappeared from the black markets. The only reported seizures of Turkish opium are from old stock.

Within Turkey itself, less than 20 pounds of opium gum and base morphine have been seized since the resumption of cultivation in 1974.

Opium poppy is a traditional crop integrated in the economy of the arid Anatolian region for two millenia. The return of democratic rule to Turkey has made a continued ban on cultivation politically untenable. The first crop since the lifting of the ban was grown by about 100,000 licensed farmers over 50,000 acres; the present expanded crop is to be gathered by 200,000 growers farming a total of 125,000 acres. Expected revenues are unlikely to be proportionately greater than last year because of untimely frost and rains.

Turkey's resumption of opium poppy growing was "a courageous decision, even a gamble," says Professor Reuter. It was a risky decision, says De Beus, because the dry straw system had never been tested on such a large scale. But its success has persuaded the two UN agencies to continue their support.

So far, the UN has financed the purchase of a fleet of 100 land vehicles, light aircraft and telecommunications facilities for surveillance as well as storage facilities. There have been discussions of the possibility of raising international finance for a modern domestic pharmaceutical industry. All of which may well tempt other countries to emulate the Turkish example — and UN officials are taking great pains to discourage them.

Traditional poppy processing (above) is no longer allowed in Turkey.

They explain that the Turkish poppy area is uniquely suitable for controlled cultivation because the flat plateau cannot hide unauthorized poppy fields from aerial reconnaissance while it offers easy access to mobile land teams.

In many other countries, particularly in south-east Asia, poppy cultivation is prohibited but the governments are incapable of exercising adequate control. Narcotics officials here fear that some of them are now tempted to legalize local poppy cultivation, bringing a lucrative end to their prolonged international embarrassment.

Without naming names, the Narcotics Control Board has issued a statement "strongly warning the governments of these countries to abandon any such plans ... Effective control of the production of opium calls for special techniques and procedures which the present (legally) producing countries have taken a long time to develop.

"The impossibility of exercising effective control would be bound to operate to the advantage of illicit traffickers."

Family MDs get aid with alcoholics

STRATFORD, ENGLAND — An "at risk" register of factors to help the British family physician spot alcoholics or problem drinkers has been drawn up by the department of general practice at Manchester University.

Dr Rodney Wilkins told the meeting here of the International Society of General Practice that a family physician with an average practice of 2,500 patients would probably find at least 30 alcoholics of whom he is unaware. Most doctors are only aware of about three alcoholics per practice.

Analyzing the register, Dr Wilkins said there is a 100% probability that a patient is an alcoholic if he has the shakes, admits a previous drunknness offence, and/or seeks help for a drinking problem.

There is a 75% probability of the patient being alcoholic if he smells of alcohol at a consultation.

There is a 50-50 chance of alcoholism if the patient has a peptic ulcer or gastritis, has an accident at home, is obese if a man, lives in a hostel for down-and-outs, or has a family history of abnormal drinking.

There is a 25% risk if the patient is anxious or depressed, has had an accident at work, is employed in the catering or brewery business, is divorced or separated, is a single man over 40, or if there is a history of marital discord.

Other risk factors, Dr Wilkins said, although small in number, are the appearance of epilepsy for the first time after the age of 25, attempted suicide, a car accident, a second marriage, and being the parent of a child with psychological or psychosomatic disorders.

Dr Wilkins said that if physicians can detect the alcoholic at an early stage "we will reduce morbidity and mortality, save the country money, and cut down on our workload."

He also had some words of caution: "Recognition is the essential prerequisite to offering treatment.

"But detection of the disease obtained in a devious way is certainly no guarantee that the patient will accept the diagnosis and the help offered."

Underworld drugs move into Israel

TEL AVIV — Police here say the underworld is apparently trying to introduce widespread use of heroin to Israel. They made the statement following the seizure of 151 grams of pure heroin, believed to be the largest ever single confiscation of this drug in Israel.

(The Israel Police Annual does not even have a separate listing for heroin because such small quantities have been seized until now.)

The Attorney-General, Professor Aharon Barak, recently said that 150 "hard drug" addicts were being added each year to Israel's present 2,000 hard drug addicts. He estimated that Israel has 100,000 drug users, but the overwhelming majority use hashish.

German youths drinking at an 'alarming' rate

By John Dornberg

MUNICH — With interest in cannabis and hard drugs waning, there is a dramatic and alarming shift among West German youth to alcohol.

The federal ministry for youth, health, and family affairs has revised its estimate of alcoholics upward from 900,000 to 1.5 million and believes 100,000 of them are juveniles under 18 years of age.

In Northrhine-Westphalia, largest of the West German states, encompassing about one-third of the country's entire population, a recent study revealed that 16% of all youth, aged 12 to 13 and 45% of the 14-to-17-year-olds have been "totally inebriated" at least once in their lives.

West Germany's youth are drinking more than ever. Authorities believe worry over school grades and competition for limited enrollment in universities may be part of the reason.

That state's ministries for labor, health, and welfare, and education have now issued educational materials such as a syllabus called Alcohol — Drug Number One which will be introduced in secondary school civics and social problems classes in the fall semester.

The federal ministry of transport sees a corollary between rising teenage alcohol abuse and an increase in traffic accidents involving two-wheeled motor vehicles such as scooters and motor bikes.

In 1974, the latest year for which statistics are available, there were 457 fatalities and 8,240 serious injuries of operators of motorbikes.

More than half of the dead and injured were juveniles aged 14 to 18.

"Even the smallest amounts of alcohol," said Horst Gehrke, a transport ministry spokesman, "seems to lead to speeding and reckless behavior among teenaged operators of two-wheeled motor vehicles."

The syllabus prepared by Northrhine-Westphalia places special emphasis on the dangers of operating mopeds, motor bikes, and scooters under the influence of alcohol.

Northrhine-Westphalia researchers are currently examining the relationship between juvenile alcohol consumption and "school stress," a national plague which has emerged in recent years.

School stress is generally regarded as the mounting performance pressure placed on West Germany's young due to the limited space in universities and lack of job training opportunities.

More than half of West Germany's 80,000 high school (gymnasium) graduates this spring were unable to gain university admission because institutes of higher learning are hopelessly overcrowded.

A complicated national grading and placement system bars any graduate with less than a B-plus average on the final Abitur exams from admission. The pressure for grades and performance is so high that there were more than 500 suicides last year by teenagers worried about grades.

"Substandard school performance," according to one Northrhine-Westphalian official, "seems to be one reason why teenagers are taking to the bottle."

NZ program under study

AUCKLAND, NZ — The New Zealand Government is considering establishing an alcoholic liquor advisory council, financed by a levy on all liquor sales.

If the Government follows the advice of a Royal Commission which reported last year, the council will introduce "a co-ordinated national policy towards alcohol problems and gradually bring about changes in New Zealand drinking patterns".

New Books

by RON HALL

Promoting Health in the Human Environment

. . . edited by Evelyn E. Meyer and Peter Sainsbury

The role of personality development, culture, socioeconomic and other factors in the human environment which play a part in health are the concern of the first of the three main sections of this book. The second edition outlines the ways health services can prevent the negative consequences and can make use of knowledge about psychosocial factors to restore and promote health. Conclusions and recommendations are included.

(World Health Organization — Information Canada, 171 Slater St., Ottawa, Ont., K1A 0S9. 1975. 69p.

Schizophrenia: A Multinational Study

In this summary of the initial evaluation phase of the International Pilot Study of Schizophrenia, it is reported that groups of schizophrenic patients were identified as having similar symptoms regardless of country or culture. The study also demonstrated the feasibility of developing internationally applicable research instruments and procedures, and of conducting reliable, large-scale international psychiatric studies.

(World Health Organization, Public Health Papers No. 63 — Information Canada, 171 Slater St., Ottawa, Ont., K1A 0S9. 1975. 150p.

Other Books

Canadian Whiskey: The Product and the Industry — Rannie, W. F., Publisher, Lincoln, 1976. 176p.

The Drug Alternative — Winn, Mitchell. American Alliance for Health, Physical Education, and Recreation, Washington, 1974. Pressures and risk taking, decision making values 71p.

The Narcotic Drug Problem — Bishop, Ernest, S. Arno Press, New York, 1976. Reprint of 1920 edition, nature of the disease, mechanism, treatment, laws, legitimate use 165p.

Clinical Aspects of the Teratogenicity of Drugs — Nishimura, Hideo, and Tanimura, Takashi. American Elsevier Publishing Company, New York, 1976. Pharmacology, survey of malformations, potential hazards of drugs, preventions, references, index. 453p.

Marijuana and Health: In Perspective — National Institute on Drug Abuse, US Government Printing Office, Washington, 1976. Summary with comments on the fifth annual report to the US Congress. 20p.

Keep Off The Grass — Nahas, Gabriel G. Thomas Y. Crowell Company, New York, 1976. A scientist's documented account of marijuana's effects. 205p.

The Drugging of the Americas — Silverman, Milton. University of California Press, Berkeley, 1976. References, index. 147p.

Social Functioning Patterns in Families of Offspring Receiving Treatment for Drug Abuse — Cannon, Sharol Rae. Libra Publishers, Rosalyn Heights, 1976. References, appendixes. 104p.

Coming Events

To provide our readers with adequate notice of forthcoming events, please send announcements as early as possible to: The Journal, 33 Russell St., Toronto, Ont., M5S 2S1.

September

Abstainers' Conference — Sept. 3-6, 1976, Minneapolis, Minnesota. Information: Virgil Magnuson, International Organization of Good Templars, 4740 6th St., NE, Minneapolis, Minn., 55421.

2nd International Symposium on Victimology — Sept. 5-11, 1976, Boston, Massachusetts. Information: 156 Federal St., Boston, Mass.

27th Annual Meeting of Alcohol and Drug Problems Association of North America — Sept. 12-16, 1976, New Orleans, Louisiana. Information: ADPA, 1101 15th St., NW, Washington, DC, 20005.

AADAC School on Alcohol and Drugs — Sept. 22-23, 1976, Calgary, Alberta. Information: Sharon Fogarty, Conference Coordinator, AADAC School on Alcohol and Drugs, 812-16th Ave., SW, Calgary, Alta., T2R 0T2.

Alcoholism: Advances in Medical and Psychiatric Understanding — Sept. 25-29, 1976, London, England. Information: Alcohol Education Centre Ltd., The Maudsley Hospital, 99, Denmark Hill, London, SE5 8AZ.

First World Conference on Therapeutic Communities — Sept. 27-Oct. 1, 1976, Katrineholm, Sweden. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

October

Familie und Suchterkrankung — Oct. 4-7, 1976, Dusseldorf, Germany. Information: DHS, D-47 Hamm, Postfach 109, German Federal Republic.

2nd International Symposium on Alcohol and Aldehyde Metabolism — Oct. 16-17, 1976, Philadelphia, Pennsylvania. Information: Dr R. G. Thurman, 409 Anatomy-Chemistry Building, University of Philadelphia, Philadelphia, Pa, 19174.

4th Congress of the Comite National de Defense Contre L'alcoolisme — Oct. 14-16, 1976, Strasbourg, France. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct. 20-23, 1976, San Diego, California. Information: Pamela Maroe, ALMACA, Suite 410, Reston International Center, 11800 Sunrise Valley Dr., Reston, VA., 22091.

Ontario Hospital Association Annual Convention — Oct. 25-27, 1976, Toronto, Ontario. Information: Hilary Short, Ontario Hospital Association, 150 Ferrand Dr., Don Mills, Ont., M3C 1H6.

20th Annual Conference of the American Association for Automotive Medicine — Oct. 31-Nov. 3, 1976, Atlanta, Georgia. Information: James Fell, National Highway Traffic Safety Administration, N43-32, 400-7th St., SW, Washington, DC, 20590.

November

Alcoholism and the Overseas Employee: Problems Facing Organizations with International Operations — Nov. 7-10, 1976, Toronto, Ontario.

1st National Conference on Issues in Juvenile Justice and Child Development — Nov. 14-17, 1976, McAfee, New Jersey. Information: Ronald Krate, Department of Psychology, William Paterson College, Wayne, NJ, 07470.

International Conference on Alcoholism and Drug Abuse — Nov. 20-25, 1976, Baghdad, Iraq. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

1977

7th International Conference on Alcohol, Drugs, and Traffic Safety — Jan. 23-28, 1977, Melbourne, Australia. Information: ICAA, Case Postale, 140, 1001 Lausanne, Switzerland.

6th International Conference of the World Union for the Safeguard of Youth — May 31-June 4, 1977, Geneva, Switzerland. Information: World Union of Organizations for the Safeguard of Youth, 28, Place Saint-Georges, F-75442 Paris, Cedex 09, France.

23rd International Institute on the Prevention and Treatment of Alcoholism — June 6-10, 1977, Dresden, German Democratic Republic. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

7th International Institute on the Prevention and Treatment of Drug Dependence — June 13-15, 1977, Dresden, German Democratic Republic. Information: ICAA, Case Postale 1401, 1001 Lausanne, Switzerland.

International Medical Symposium on Alcohol and Drug Dependence — Aug. 21-26, 1977, Tokyo and Kyoto, Japan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Life's a series of crises for the young alcoholic

EASTBOURNE, ENGLAND — Long-term treatment of young alcoholics is going to be, at best, the management of a series of crises over the years, says psychiatrist John Gayford, head of the Alcoholic Unit at Warlingham Park Hospital, Surrey, near London.

A recent study of an Alcoholic Unit in England found that 30% of the patients presenting for treatment were under the age of 30.

Dr Gayford told the Royal Society of Health conference here: "It is alarming how quickly young people can develop the full alcoholic syndrome, with amnesic episodes, morning drinking to relieve alcohol withdrawal symptoms, and even delerium tremens."

Dr Gayford, who has also done several studies on battered wives, added: "The person with the prospect of another 50 years of life ahead is not as likely to accept total abstinence as a way of life for the rest of his days as is a man in his mid-forties.

"Although many of the youngsters have damaged their lives with alcohol, they have probably not suffered as much as the older person."

Sensory deprivation

Tranquillity or panic?

'The world had gone: the universe now extended to the boundaries of my body'

VANCOUVER — The padded, vault-like door closed with a muffled thud.

Five minutes later, the lights went out leaving a velvety, penetrating blackness that didn't lighten with the passing minutes as experience said it should. Sound absorbing material on the walls of the room softened the silence and made it press on my ears.

The world had gone: the universe now extended to the boundaries of my body.

I had begun my 24 hours of sensory deprivation.

* * *

I volunteered for the experiment to try to get some insight into how this experience changes people's lives — helping them quit smoking, stick to a diet, or conquer their fear of snakes.

The experience would likely, I had been told, be mildly pleasant, or boring even, but if I didn't like it I could leave at any time.

Meanwhile, I could have water or vanilla-flavored diet drink by turning my head and sucking on a plastic tube.

Change, keys, and wristwatch — all potential distractions — had been surrendered before I went in, so it was difficult to keep track of time.

But, it was after about an hour, I think, that I heard the first strains of a symphony which was to keep me entertained for many hours.

The overture was the beating of my own heart, which I both felt and heard. Then there was a rushing noise, the sound, I guess, of blood rushing through tiny vessels in my inner ear, and then, a high pitched singing — a memento of the noisy world I had left behind.

Digestion of lunch provided a fugal counterpoint.

There was visual drama, too. Phosphenes, the shifting specks of light we see even in total darkness thanks to the spontaneous firing of nerve cells, formed intricate patterns and Dali-esque images.

I was aware of each part of my body; the twitch of an obscure muscle was an event to be noted and a sneeze was like a clash of cymbals.

But the symphony wasn't intrusive and I could shut it off at will, or drift into sleep, as one might when lying in the sun on an August afternoon.

I drifted from dreaming into waking, only to find that waking was also a dream. A dream mistaken for waking accounted for the closest thing to a "hallucination" I experienced — the voice of a child crying out and some weird sounds, like a dozen springs being released.

I was, in fact, frequently bored, and then I would sleep. The lazy existence had become quite pleasant, when the voice of the monitor came through the intercom to tell me the session was over.

Afterwards, it seemed I had been in the chamber for only an hour or two, and I felt cheated of the 24 hours, as a traveller might who has just crossed the International Date Line.

I didn't go into the chamber with any specific bad habits that I wanted to lose. But the experience had an effect.

For several weeks, I was noticeably more tranquil. It was easier to order my life, and would have been easier, had I wished it, to re-order it.

If I had to analyze the effect, I'd say a lot of busy, distracting internal conversation had left me — perhaps used up in that 24 hours of dialogue with myself.

UBC team is 'very excited'

Quit-smoking therapy promising

VANCOUVER — What could be the most powerful quit-smoking therapy ever developed is being tested now at the University of British Columbia.

Preliminary results are "very exciting" and suggest that the six-month cure rate may be as high as 80% or 90%, according to the psychologists running the experiment.

The therapy combines over-smoking, one of the most widely-used and successful ways of breaking the smoking habit, instruction in finding substitutes for smoking, and, the most unique component, a single 24-hour session of sensory deprivation.

Sensory deprivation has fascinated psychologists for two decades.

McGill University psychologist Don Hebb did the first important human experiments, equipping volunteers with translucent goggles and ear phones that played white noise. Deprived of patterned stimuli, the subjects reported bizarre effects — mood swings, and hallucinations — and most of them quit the sessions after one or two days.

Other researchers further eliminated sensation, using dark, soundproofed, and anechoic rooms. One, California psychiatrist John Lilly, floated his subjects naked in a bath of warm water to enhance the effect. (Lilly has since drifted into mysticism and is now attempting to use sensory deprivation to achieve communion with the supernatural.)

The exotic experiments gave sensory deprivation an undeserved "bad name," according to Peter Suedfeld, head of the UBC psychology department and one of the "modern" pioneers in sensory deprivation.

"When you act as though scary things will happen, scary things happen," he said in a recent interview, recalling how, the first time he tried sensory deprivation, he was first given a release to sign, in case he went insane, and then was taken to the sensory deprivation chamber where the first thing he was shown was a "panic button" which he could use to gain his freedom.

"That was the first time it had occurred to me that I might panic," he said.

Psychologists learned that if they promoted anticipation of a pleasant and unremarkable experience, the bizarre and unpleasant features largely disappeared.

If sensory deprivation thus become less interesting for writers of detective and science fiction, it became more interesting for the scientists as it emerged that there might be important applications of the technique.

Features by Tim Padmore

"I became interested in attitude change," said Dr Suedfeld, "and I thought it was important to study attitudes which were important to the subject, which have an impact on his life."

Politics and religion were obvious choices, but were out for ethical reasons, he said, so he settled on smoking.

Forty hardened smokers, all of whom had failed in at least one previous attempt to quit smoking, were subjected to a 24-hour session of sensory deprivation.

Two years later (one of the longest followups in the quit-smoking literature) the group was smoking 50% less, and 25% had quit completely.

Six month follow-up results for sensory deprivation seem to be settling in around 50%, roughly the same as for the various oversmoking techniques.

Over-smoking is, basically, smoking so much you can't stand it any more.

There are two popular techniques: saturation smoking, where the smoker doubles his normal consumption of cigarettes and then quits, developed by Jerome Resnick of Temple University in 1968; and rapid smoking, where the smoker increases his puffing rate by a comparable factor. The latter was invented by Gerry Wild, of Queens University, and Cyril Franks, of Rutgers University, in the mid-sixties but not applied with consistent success until recently.

Over-smoking makes the subject dizzy and nauseated, and the ordinary accompaniments of smoking, coughing, and a bad taste in the mouth, are magnified enormously.

Usually, it is easy to stop cold-turkey after this treatment. Initial quit rates are often 90% or more.

The rub is staying stopped. The rule of thumb, says UBC psychologist Allan Best, is that 75% of the people who quit will be back on cigarettes in six months.

Dr Best has been trying to beat those percentages by supplementing the short term oversmoking therapy with a long term management program designed to substitute other behaviors to satisfy the subject's needs.

The physical craving is quickly over with, he says, but the need to relieve boredom, ease tension, reward hard work, or just round off a satisfying meal, remains.

"Smoking does a lot of good things," he points out, and the goal of the long term self-management program is to devise coping strategies to fill the "void" left by eliminating cigarettes.

(This type of need is recognized as a major factor in opiate addiction. The satisfactions associated with being a part of a tightly-knit subculture and the relief from responsibility and stress provided by heroin are cited as being a bigger barrier to abstinence than the pain of withdrawal.)

Specific coping strategies range from relaxation exercises to preparation of a pat answer for a friend who offers cigarettes at a party.

Dr Best has been running groups through variations of the over-smoking-self management program at UBC for more than a year, with a six-month success rate of around 50%, one of the very best rates reported outside the labs which originally developed the over-smoking techniques.

The refining continues: recently program staff went up and down the Tsawwassen car ferry line-ups questioning motorists and passengers on their motivations for smoking. One finding: people's reasons are remarkably specific. For example, people don't smoke just because they're upset about something, they smoke when they're depressed but not when they're angry, or vice versa.

However, by far the most dramatic results seem likely to come from Drs Best and Suedfeld's decision to merge their techniques.

In a preliminary study, five of six smokers were abstaining after three months of the combined therapy which comprises the sequence: satiation smoking, 24 hours of sensory deprivation, quitting self-management.

The current experiment, Dr Best told **The Journal**, involves three groups of about 10 people each, one group on sensory deprivation alone, one on the satiation smoking, and one on both. The follow-ups vary from one to three months and so far nine of 10 in the group on combined treatment are still off cigarettes, compared with 30% to 50% of the others.

"It looks very exciting. The data are preliminary, but it sure looks solid."

(Some commercial quit-smoking centres claim cure rates upwards of 80%, but the claims, said Dr Best, are largely undocumented and the centres may bias the outcome by accepting only highly motivated clients.)

What is the magic of sensory deprivation?

In Dr Suedfeld's original experiment, and in this one, subjects received anti-smoking messages at certain times during the deprivation period.

"Aha!" the sceptic might say. "It's obvious that the subject was so starved for stimulation that he blotted up the message and it was imprinted on his psyche."

Unhappily for that theory, Dr Suedfeld's first experiment was carefully controlled — some got messages, and some got the sensory deprivation alone — and the messages, remarkably, made no difference at all.

Dr Suedfeld says he still believes in the message theory, however, citing results of another UBC experiment, treating obesity, where the messages did make a significant difference. The anti-smoking messages were too simple, he says, and told the smoker little he hadn't heard before.

Dr Best said that in undergoing sensory deprivation, the smoker has also, and with relatively little distress, done without cigarettes for 24 hours, the sacrifice being eased by the absence of the usual cues and the distraction of the novel situation. That in itself is a substantial encouragement to quit.

Maybe it is simply the opportunity for

(See — It — page 10)

THE BACK PAGE

The Journal

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Peter Bourne (left) and US presidential candidate Jimmy Carter

Heroin decriminalization

Bourne predicts changes

By Anne MacLennan

NEW ORLEANS, La. — The move to decriminalize heroin is gathering force and will ultimately be successful, predicts Peter Bourne, US presidential candidate Jimmy Carter's chief campaign organizer and adviser on health affairs.

In an interview here with **The Journal**, Dr Bourne, a consultant to the US Drug Abuse Council, termed the issue of heroin decriminalization "politically charged" and emphasized he was not calling for decriminalization but rather predicting it would happen.

He said while people in the substance abuse field have "probably learned the most and moved the most" in the area of prevention, there has been one major problem: "We tend to view the seriousness of drugs in terms not of their physical or social consequences but more in terms of the legal condolence for or against them in society.

"We regard heroin as the consummate evil and tend to forget that 50,000 die in the United States each year of lung cancer, half of all fatal automobile accidents are alcohol-related, and alcohol is the fourth leading cause of death.

"This is changing. Now, states that have decriminalized marijuana, and a number of others, are moving to an awareness that not everybody that gets involved with heroin becomes addicted."

More important, he said, is the growing recognition that probably the greatest evils associated with heroin have to do with economic consequences of its use rather than physiological effects.

"Heroin has created a remarkably profitable business which has corrupted police departments and cities, and large numbers of heroin trafficking businesses. The risks in its use are probably far greater because it's illegal

(See — Health — page 7)

Two provinces okay spot tests

By Bryne Carruthers

OTTAWA — Ontario and Alberta have announced they will implement the new federal law allowing police to demand roadside breath tests from drivers suspected of being impaired.

But while the law in the two provinces came into effect in mid-September, actual implementation isn't expected to start for another few months, while police forces develop procedures, train personnel, and test equipment.

Meanwhile, other provinces continue to wait in the wings (**The Journal**, September), supposedly in the hope that less expensive testing equipment will be approved by federal authorities.

Alberta and Ontario will be using the Alcohol Level Evaluation Roadside Tester (ALERT) that flashes a red light when the alcohol content in a suspect's breath is close to the legal level of impairment (0.08%).

Drivers unfortunate enough to be stopped outside their favorite drinking spot, and subsequently to trigger the red light in the roadside test will be taken to a police station for official breathalyzer test which would be used as the basis for any formal charges.

One of the sore points of the new law is that it seems to interfere with an individual's civil rights.

Police must have reasonable suspicions that a driver is impaired before the screening test can be given. This will likely be accomplished by testing individuals emerging from taverns and other drinking spots.

The controversial aspect is that refusal to take the test could result in the same penalties being imposed as those received by persons actually convicted of impaired driving: a $50 to $1,000 fine, up to six months in jail, or both, on a first offence; a minimum two weeks in jail on a second offence; and a minimum three months in jail for a third offence. Driving licences will also be suspended for periods of six months or longer.

(See — Roadside — page 7)

Coin-operated breath testers are being installed in a growing number of Ontario taverns.

Roadside breath tests for those suspected of being impaired will soon be implemented in Alberta and Ontario.

UK women being jailed for drunkenness

By Alan Massam

LONDON — Although British law regards excessive drinking as a problem requiring treatment rather than punishment (since the passing of the Criminal Justice Act of 1967) more and more women are being sent to prison here for being drunk.

This strange and disturbing anomaly has been emphasized in a joint report by one of London's largest voluntary welfare agencies — the Camberwell Council on Alcoholism — and a national pressure group, the Campaign for the Homeless and Rootless.

The CCA and CHAR report notes that the needs of alcoholic women in Britain are even more neglected than are the needs of alcoholic men. There are only 67 beds for them in specialist hostels for homeless alcoholics in the whole of England and Wales, compared to 376 beds for men, although in 1971 a Home Office working party recommended that there should be 200 such beds for women and 2,000 for men.

Mostly, the report expresses concern for the habitual woman drunkenness offender who seems to be "at the bottom of a vicious spiral".

Such woman are rejected by their families, become homeless, and take to begging to get the price of a bed. They also resort to prostitution and shoplifting to get money for drink.

In 1974, the report says, about 7,000 women in England and Wales were sent to prison for drunkenness compared to 4,437 ten years earlier.

The authors of the CHAR/CCA report note that heavy drinking in women tends to be overlooked for longer than it is in men because of the difficulty of detecting females with an alcohol problem.

They go on: "The present system allows for no anticipation or de-escalation of the downward spiral in which a woman who is drinking heavily can become homeless and engage in offences such as soliciting to get money for drink or to obtain a bed.

"Once this position is reached, these women, although possibly defined as alcoholic, are not given the rights to medical or psychiatric treatment afforded to alcoholics in more fortunate social circumstances, or whose alcoholism is diagnosed in medical setting."

This accounts, the report concludes, for the fact that the majority of women in specialist hospital units for alcoholics are the "better-off" type who have support from their families.

The needs of the habitual woman drunkenness offender would best be served by more walk-in advice centres staffed by women who have themselves experienced drinking problems, it adds.

Dramatic risks for teen drunk drivers

OTTAWA — Drunk drivers aged 16 and 17 years face a risk of being killed in an automobile accident that is a startling 165 times greater than the average non-impaired highway driver.

This is one finding of a statistical study prepared by the Traffic Injury Research Foundation of Canada (TIRF).

In a report summarized in its newsletter, the TIRF notes the risk of a fatality while mixing driving and drinking drops sharply with higher age — and supposedly with increased experience as to how and when to drive — to the 30 - 34 year bracket and then rises again.

The 18-19-year-old impaired driver runs a risk 70 times that of the average, non-impaired driver of being killed in a crash, says TIRF.

The 20 - 24 age group faces a 31 times greater risk; and the 25 - 29 year bracket faces a 27 times greater risk.

The "safest" age group, at least statistically (if "safest" is the appropriate phrase), is the 30 - 34 group, which runs a 17 times greater risk of a fatality in a car crash.

The risk for the next age group, 35 - 44 years, is higher again,

(See — Age — page 7)

Inside

'We have more than enough alcohol information'

By Betty Lou Lee

HAMILTON — There is now more than enough information about alcohol and its effects to help communities plan their attacks against its abuse, says the

Douglas MacDonald

director of clinical services at Donwood Institute, Toronto.

"The higher we fly with plans, options, and therapies, the farther away we get from those who need it," Douglas MacDonald told the 17th Annual Institute on Addiction Studies at McMaster University here.

"As professionals in the field, we must ask ourselves where our contribution lies. Are we content, as many are, with the incessant gathering of more and more data, to toiling in our laboratories and clinics quietly, without regard for what is happening in the world?

"We must step up educational efforts so that society knows the danger and the cost, we must develop ways of early case finding . . now we don't get many until they get to the emergency room.

"We have to develop reasonable plans for therapy and rehabilitation where possible, and we must make efforts to be more involved in the evolution of social and government policy. Above all, we must help originate the options available to a society weighing its actions. I do not believe we have been singularly successful in any of these areas in the past," Dr MacDonald said.

At his own centre, the trend is towards treatment at day clinics, rather than the present two-year program which includes one month of living at the institute. The cost of a day program is $1,000 per patient per year, just half the cost of the combined in- and out-patient regime.

Figures from the Donwood show that 89% of patients benefit after the first year of treatment: 35% are abstinent, 25% have had one slip, and 29% have moderated their drinking habits.

Dr MacDonald said it is good business to rehabilitate alcoholics, and government would be short-sighted to curtail funds in this field. In Ontario, it costs government more to repair the results of misuse of alcohol than it gets in taxes from its sale, he said.

A study of Donwood patients one year before and one year after treatment shows they have 35% fewer visits to doctors, 45% less hospitalization, 65% fewer legal charges, 80% fewer impaired driving charges, and spend 75% less time in jail.

Dr MacDonald said a rehabilitation program has to give the patient security, identity, and stimulation to avoid the boredom that comes easily. In times of stress, the patient must learn to turn to people, not to alcohol or pills.

He described the first year of Donwood treatment as a stormy one of transition that often includes anxiety, panic, insomnia, inability to work or make decisions, diarrhea, anger, frustration, fatigue, and impotence.

Among those available for support, counselling, and friendship in the program, are nurse counsellors, recovered patients, and clinical secretaries — local housewives who keep in weekly touch by phone, mail or visits.

The second year is one of consolidation, where old social relationships are required or a new community has been established. The physical status is improved and new life styles have been adopted.

Dr MacDonald said there should be no consolation in the fact that only 6% to 7% of the population is abusing alcohol. The percentage rises with per capita consumption: it reaches 9% when per capita drinking is 15 litres a year, and 20% at 25 litres.

It is "pure chicanery" for breweries to maintain that their commercials are aimed at brand switching. "They are trying to start new drinkers." He cited Hockey Night in Canada commercials, watched by many Canadian children, in which "everyone is handsome, young and beautiful — and drinking a helluva lot of beer".

He considered alcoholism as probably the commonest cause of illness and death, not third or fourth, and the commonest undiagnosed illness. "The patient's diagnosis may be a broken hip, but no one diagnoses why he fell."

The institute is sponsored by Alcohol and Drug Concerns Inc. of Don Mills, Ont.

UK report highlights high costs of drinking

LONDON — British Government officials and politicians have been given yet another warning of the high social and financial cost of alcohol consumption.

A report from the department of the environment's Transport and Road Research Laboratory suggests that a quarter of all drivers involved in road accidents have been drinking and 9% of the accidents are directly caused by alcohol consumption.

It adds that the problem of drinking and driving between 10 pm and 4 am are "even more serious than hitherto assumed". About 70% of accidents within these hours involve a drinking driver and in nearly one third of them, alcohol is "a major contributory factor".

But the survey's analysis of the ages of drinking drivers gives most cause for concern. It shows that 40% of drivers in the 16 to 24 years age group randomly sampled are likely to have been drinking. In the 16 to 19 years age group, the proportion goes up to more than 50%.

Confirmation of the rapid increase of drinking among young people in the UK coincides with a report from the ministry of agriculture, fisheries and food which shows that between 1972 and 1975, overall consumption of beers and spirits rose steeply (spirits from 3.4 to 4.5 pints per head per year; and beers from 189.3 to 206 pints per head per year).

There was, however, a falling back in the consumption rate when prices increased in 1975.

These two reports are thought likely to add weight to calls for stiffer penalties for drinking drivers and for greater investment in health education about excessive drinking.

Research, education centre set up

Mexican alcohol campaign under way

ACAPULCO — Drug traffickers will wind up in jail as usual in Mexico, but substance users will be treated as people in need of medical attention.

This was the message from Rafael Velasco Fernandez, director general of mental health in Mexico to the World Congress of the International Commission on Alcoholism and Drug Dependency here.

"We plan to use a medical treatment plan because that's the way we consider them — as sick people. Treatment is already being carried out in general hospitals.

"But Mexico will continue to take action against Americans, or those of any nationality, who violate drug laws on Mexican soil," he warned.

"This is not a problem of mental health," Dr Velasco said, adding that "several" Americans remain in jail on drug charges.

Alcoholics and those with a drinking problem are also receiving the attention of the Mexican government, with the establishment of a centre to study the problem and educate the public about it, Dr Velasco reported. Although there has been a rehabilitation centre for alcoholics in the country since 1959, as well as other treatment centres for acute intoxication, this has not been sufficient, Dr Velasco said.

"Between the years 1971 and 1975, the only thing that can be said with certainty is that (alcoholism) has increased — due to the natural growth of the population and the increased per capita consumption of alcoholic drinks."

Dr Velasco estimated there were 660,000 Mexicans incapacitated by alcoholism in 1970, and by 1980, 900,000 will be affected.

"This figure does not take into consideration the excessive drinkers, nor those alcoholics who have not yet become disabled. If by utilizing the present figures we apply these percentages to a population of a little more than 70 million inhabitants expected in 1980, we can be sure then that in that year we will more than pass the figure of three million Mexcians with grave problems of alcoholism.

The planned campaign will involve epidemiological studies on the incidence of alcoholism as well as the psycho-cultural factors contributing to it. The prevention of mental disturbances, the formation of a specialized personnel unit for the early identification and treatment of alcoholics, and the rehabilitation of those who are incapacitated by alcohol are additional segments of the Mexican campaign.

Drug pamphlets favored by young people

ALBANY, NY — More young people here would rather read a pamphlet about drug abuse than turn to family, friends or teachers for information on the subject.

That was one of the findings of a study — *Drug Abuse Prevention: The Awareness, Experience and Opinions of Junior and Senior High School Students* — released by the state Office of Drug Abuse Services. The report is based on data from questionnaires completed by 8,553 students who were in grades seven through 12 during 1974-75.

Researchers found that as the students' grade levels increased, they were more likely to feel there was a drug problem in their school. About 40% of the students said they thought there was a drug problem; a large number — 52% — said their teachers believed there was a drug problem.

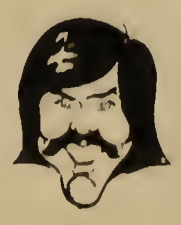
"As students get older or more into drugs, they rely less on family and institutional help and more on drug-using peers and former users for help with drug problems or information," the study found. Only pamphlets were judged believable among the media.

"These results suggest the need for students to be exposed to prevention efforts they feel are most effective," the report said.

"In any prevention effort involving audiences with diverse substance use patterns, it would be wise to include a range of topics covering the social, personal and medical aspects of drug use . . . to expose youths to different views of how drugs relate to their lives," the report concluded.

Hey the adman's thy shepherd, guys and girls

By Wayne Howell



Memo to: All Beer Barons
From: Yonr Advertising Agencies
Re: Subject of Mutual Interest

Once again, it appears, the Carrie Nations in Canada's federal and provincial governments are grumbling about our television suds-selling. Health minister Marc Lalonde says he wants to put the squeeze on the Canadian Radio and Television Commission to "eliminate lifestyle advertising", and Terry Jones MPP and author of the Ontario Report on Youth and Alcohol wants to censor beer advertising which he claims "equates the consumption of alcohol with the beautiful life".

Now you know and we know that the sole purpose of our televised beer ads is — and always has been — to promote *Brand Preference*. Take our Molson's Golden ad for instance — a party scene with the refrain 'make sure you're holdin' Golden' repeated over and over again. *Brand Preference* — right? It's just coincidence that all the people holdin' Golden at that party, the people who spout all those wacky one-liners, perfect puns, and neat non-sequiturs just happen to look like the cast from an old Annette Funicello surfing movie. For it's our own provincial and federal governments that are always encouraging us to hire students, right? And then they turn on us, accuse us of nefariously scheming to tickle old Freudian fancies, when all we are trying to do is be good corporate citizens!

It is hard to be rational in these circumstances, especially when we have to put up with the most outlandish accusations. Take, for instance, the claim that we never show anyone over the age of 25 in our beer commercials. Now this is utter nonsense; there was an old farmer in a Labatt's Blue ad . . . . . once. And there is that middle-aged fellow who comes home to his 50 on the bus. 'Comin' home to my 50 . . . . .', *Brand Preference* — right? Now it is true that once he cracks open his case of 50 he is suddenly joined by a group of grinning post-adolescents, but what's so unusual about that? He's got to have neighbors — right. But instead of coming to the obvious conclusion — like maybe this guy just happens to live next door to a college fraternity or sorority or something — these people come to the bizarre conclusion that we are mixing the young with Jung, tampering with the collective unconscious, and in some subliminal way suggesting that the drinking of beer will help you make friends and meet interesting people!

You know and we know that this is nonsense. However, since these people seem serious you will be glad to know we are looking around for alternative ways to promote *Brand Preference*. Unfortunately, it is not going to be easy. Recently we shot some experimental footage of the classic 'Freddy and the boys . . . . . ' routine using over-60 actors coming back from a friendly game of lawn bowling. They cracked open the case . . . . . but somehow it just didn't have the right effect, the *Brand Preference* effect, we look for. As a matter of fact, the sight of those old codgers grinning and waving their bottles about was absolutely . . . . . well let's just say it was counter-productive to marketing strategy. And so it's back to the drawing board. But have no fear — even though these meddlers are threatening to lead us into the valley and shadow of censorship. For your ad agencies and their staff are with you. We'll think of something.

(Wayne Howell is an Ottawa physician and freelance writer).

Government getting stricter on liquor ads

BC publishers ward off some nasty surprises

By Tim Padmore

VANCOUVER — British Columbia magazine publishers are digging in their heels against a ruling banning liquor advertising on the back pages of their magazines. They see the move as the first step to a total ban.

The protest follows circulation recently of a letter from the Liquor Administration Branch (LAB) to publishers reminding them of the two-year-old, but rarely-enforced, ban on back-page ads.

The favored position typically costs advertisers an extra 20%.

"It's not the 20%, it's the thin edge of the wedge," said Gerald Kidd, president of the BC Magazine Publishers Association.

He said the rule is discriminatory against BC magazines, some of which get up to 50% of their fall and winter revenues from liquor ads, because they have to compete with US and Eastern Canadian magazines which make up the bulk of magazines offered for sale here.

LAB director of advertising, Ken Stewart, said the ban has not been enforced until now because the branch has been preoccupied with internal reorganization for the past year or so.

He said some publishers may soon get another nasty surprise when the branch starts enforcing another unenforced rule which limits liquor ads to 20% of total ad content.

The crackdown has nothing to do with federal proposals to restrict liquor advertising, although the province is anxious to see a national code on which to base liquor advertising regulations, he said.

Health minister Marc Lalonde is expected to introduce legislation this fall placing wide restrictions on liquor advertising.

Originally, Mr Lalonde was aiming the laws at television and radio stations, but he recently assured broadcasting officials that newspapers and magazines would also be affected.

Vancouver alcoholism researcher, Ron Cutler, said there is little hard evidence linking alcohol advertising to increased consumption (see accompanying story), but he still supports restricting alcohol advertising.

There is little difference between the products offered by different manufacturers, so ads are designed mainly to reinforce brand loyalty, not communicate useful information, he said.

(Not that there is no information to communicate. People might be interested, for example, to learn that Seagram's Seven Crown whisky contains three times the level of congeners as Seagram's VO and 400 times that in Smirnoff vodka, he said.

And while manufacturers declare their intent is not to increase consumption but to increase their share of a pre-existing market, many ads seem to be designed to boost the drinking rate:

By making specific appeals to individuals likely to be heavy drinkers, specifically, men between 35 and 45 years who lack a firm sense of identity and sufficient self esteem;

By making appeals to groups, such as middle-class women, who were not previously regular drinkers;

By associating drinking with new types of situations, such as boating, skiing, and mountain climbing; and

By encouraging consumers to "stock up" to avoid running out, but expecting that the extra amount will be used.

Mr Cutler also admitted some reservations.

"I don't like alcohol advertising. There is nothing else which is advertised which is so clearly socially harmful. But in talking about a ban, you're opening up a can of worms, because it's conceivable the argument could be applied to other forms of advertising."

He suggested a better idea might be a heavy "advertising tax," proceeds from which could be used to promote moderate drinking.

Drink is too low-priced anyway, he said, with the price of a bottle a much smaller fraction of disposable income than formerly. (In BC that fraction declined 38% between 1955 and 1970.)

The 14-month BC experiment banning alcohol advertising probably failed because it was in force for too brief a time — a generation might be necessary, he said.

According to Mr Kidd, the magazine publishers president, it would cause several magazines to go out of business, the most vulnerable being throwaway "calendar" magazines which are distributed free and offer, along with a heavy dose of ads, short articles and information on upcoming local events.

He said the publishers were planning to meet with provincial attorney-general Garde Gardom in September and that the group is joining the Canadian Periodical Press Association in an appeal to Mr Lalonde.

He admitted he doesn't have great hopes for success.

"Maybe we can convince the government to allow non-lifestyle ads in high-quality, paid-for magazines.

"But, and maybe I shouldn't say this, it's a motherhood issue politically — you can't go wrong banning liquor ads — and I believe there will be no liquor advertisements in Canada within five years."

But ad bans don't work: ARF

VANCOUVER — Advertising of alcoholic beverages was banned in British Columbia for 14 months in 1971-72.

The effect of the ban on alcohol consumption? Zilch, according to a recently published study by Reginald Smart, of the Addiction Research Foundation of Ontario, and Ronald Cutler, a Vancouver alcoholism researcher.

The authors looked at beer, wine and liquor consumption statistics for BC for approximately the decade ending in 1974, and compared them with similar figures for Ontario.

The article in the British Journal of Addiction concludes that the ban had little or no effect on consumption. The only possible effect may have been on wine sales which showed a slight drop in the rate of increase but "because this continues far beyond the lifting of the ban it cannot be clearly attributed to it."

The ban, imposed by the then Social Credit government, was lifted when an NDP government was elected. Public support for the ban, never overwhelming, declined steadily as it continued and the final straw was probably political pressure exerted by small-town newspapers hurt by the loss of ad revenues.

Implied consent law has little impact

MADISON, Wisc. — Wisconsin's implied consent law, designed to decrease accidents by requiring an alcohol test from people arrested for driving while intoxicated, has had no effect on the number of fatal accidents or on the fraction of intoxicated drivers killed.

Toxicologists Patricia Field, Ronald Laessig, and Barbara Basteyns of the University of Wisconsin Center for Health Sciences analyzed blood samples from 2,000 drivers killed during the two years before and three years after passage of the 1970 law. They found that about 48% of drivers fatally injured in accidents were under the influence of alcohol.

"Alcohol is still heavily involved in traffic accidents. Nothing seems to have changed," said Dr Field, who is a member of the Governor's Task Force on Alcohol/Drug Use and Public Safety.

The implied consent law requires that persons arrested for drunken driving provide a breath, blood, or urine specimen for alcohol analysis. The average blood alcohol level in people tested last year was 0.2% — twice as high as the legal level for intoxication.

The high average blood alcohol levels indicate that an arrest isn't made unless the driver is thoroughly intoxicated, according to Dr Field. Officers are reluctant to arrest and transport a person to a testing site unless they are fairly certain the test will prove positive, she explained.

"The mere existence of the implied consent law did not alter socially irresponsible drinking," Dr Field said. "There is a general lack of public understanding about the conditions, such as the number of drinks consumed, body weight, and time elapsed before driving, that determine a person's blood alcohol level."

Despite the data showing no effect on the implied consent law on traffic fatalities, Dr Field said the law has had some positive influence.

"It provided law officers with an effective scientific criterion for intoxication and resulted in easier, less costly prosecutions. It also increased public awareness of the destruction caused by the drinking driver."

Intervention approach outmoded

Primary prevention's the most effective way

By Jean McCann

ACAPULCO — Incorporating options to drugs and alcohol in the treatment of a substance abuser is far more effective than employing the judgemental, legal, or rehabilitative approaches alone.

Allan Cohen

"The most successful treatment and rehabilitation techniques supplant substance dependency with powerful and positive alternatives," Allan Y. Cohen, professor of psychology at John F. Kennedy University, Orinda, California, told the Second World Congress on Alcoholism and Drug Dependence here.

Energies have been steered away from seeking prevention of substance abuse as a primary aim, he said.

"In fact, most international attention has been focused on secondary or tertiary prevention — intervening after the individual has serious substance abuse problems."

The idea of "positive alternatives to false dependencies", however, can get rid of the problem in its early stages.

The specific alternatives can include any kind of interest of the individual that actively competes with the intoxicating qualities of drugs and alcohol. This can range from recreational activities to peer group support, to service to other people, to religious and spiritual experiences to vocational experiences, Dr Cohen said.

"There's a very, very wide range available both for young people and their parents, that can take the place of drugs."

Many approaches have been tried with limited success in treating the substance abuser, according to Ernest H. J. Steed, executive director of the International Commission for the Prevention of Alcoholism.

"We've gone through the judgemental phase in many countries, where people say 'Something must be done. Stop it.' We've gone through the educational and information stage, and we've seen that information alone can sometimes make things worse. We've also gone through the phase of emphasizing rehabilitation, and while this is terribly important, it means nothing in terms of prevention.

"So now we're in phase four, and phase four is that of positive alternatives to alcohol — diversions that are so rewarding and attractive that people don't want to abuse alcohol instead," Dr Steed said.

Eric Stamp, head of native alcohol and drug programs for Alberta Indians spoke of cultural alternatives.

"We have sun dances, pow wows, pipe ceremonies, native crafts, education in tribal tradition, and sweat lodges, which are our version of the sauna."

Sports are also a promising alternative to substance abuse, according to Johannes Virolainen, former prime minister and Minister of Finance of Finland.

"There can also be an economic inducement," said Mr Virolainen, who is one of a core of Finnish legislators who are total abstainers.

Program is finding employment for ex-addicts

By Tom W. Hill

NEW YORK — A comparatively new private, non-profit organization here, made up largely of seasoned workers in the drug abuse field, has been achieving significant success in finding employment for former drug-dependent individuals.

The National Association on Drug Abuse Problems (or PACT/NADAP), set up in mid 1975 to bring together three organizations with extensive experience in the drug abuse field, enjoys the sponsorship of both business and labor.

Its list of sponsors reads almost like a Who's Who in Business, and includes names like AT&T, General Motors, Exxon, IBM, RCA, and Lever Brothers, along with several top banks, insurance companies, airlines, retail establishments, and labor unions.

PACT/NADAP was formed to bring together PACT (Provide Addict Care Today), NAPAN (The National Association for the Prevention of Addiction to Narcotics) and IACJ (The Institute for the Advancement of Criminal Justice).

The National Association of Drug Abuse Problems, established to help former addicts gain employment, conducts training sessions for supervisory personnel (above) to acquaint them with the program.

"Graduates of drug treatment programs often fall short of complete success when they fail to obtain employment," says Rev John McVernon, New York drug abuse expert, who is currently developing community contacts for PACT/NADAP.

"The depression that can come from unemployment is capable of triggering a relapse for the person with a history of drug use."

Yet a substantial number of former users are well educated and skilled, he points out. Through treatment, some have acquired interpersonal skills that are highly prized in the business world.

Seeking a solution to the practical problems of such people, PACT/NADAP mounted a campaign to create awareness in the business community that many former drug abusers have qualities employers want. Among other things, the organization has been holding seminars with management and employer groups at the rate of approximately one per month.

"Our goals are limited and realistic," says Father McVernon. "We can't expect business to be treatment-oriented."

But the educational activities are paying off in at least five directions:

1. Personnel policy changes are being made by some companies, which have begun referring drug-using employees for treatment rather than firing them outright. Five more firms have initiated studies in this area, calling on PACT/NADAP to help them formulate new drug abuse policies.

2. Acceptance of graduates of treatment programs for job interviews and employment is growing. From May 1, 1975 to the end of the year, 196 firms accepted and interviewed PACT/NADAP referrals and 123 firms hired 135 of the referred individuals.

3. Sharing of acquired drug information with line personnel and the public is occurring. Father McVernon tells of a manufacturing company that had an employee whose performance was suffering because he was worrying about a son using drugs. In a series of informal meetings the employee's supervisor was able to reassure the man, pointing out that drug usage didn't necessarily mean addiction and that addiction wasn't necessarily lifelong. His panic calmed, the employee resumed normal functioning, and a start was made in assisting the son.

4. Changed attitudes towards troubled employees in general has developed in some companies. "We show supervisors how they can't generalize from their own life experiences," says Father McVernon.

"One gifted and successful manager of a retail store chain commented: 'I don't think I'll ever feel about a problem employee the way I used to. I always thought of what a pain their problem was to *me*, and not how it must hurt *them*'."

5. Callbacks for further programs and consultations have been gratifyingly frequent.

To persuade supervisors in business and industry to accept former drug abusers often isn't easy, but the seminars help. Father McVernon tells of a major savings bank that has long had a policy of accepting PACT referrals through its personnel department. Although supervisors in different departments were aware that former drug users were being hired, they didn't know which employees they were.

"After a couple of training sessions four department heads, one of them previously opposed to the program, told the personnel chief they'd like to have a former drug dependent in their department," says Father McVernon. "Two of them were surprised to learn that they had PACT referrals in their departments already."

A motion picture production company that has long supported PACT financially but resisted hiring former drug users, called the day after a drug information seminar to make a job offer.

The initial work experience of the former drug user may be difficult and the PACT/NADAP seminars devote some time to preparing supervisors for this. Graduates of therapeutic communities, coming from the highly supportive environment of the treatment centre, may expect the same love and concern in the work environment.

There may be special problems at first with methadone patients. The tendency to nod, the occasional appearance of being drunk (especially when the medication is new to them), and a testiness and gloominess, may produce a crisis on re-entry to the working world.

'Part of the program is devoted to removing the myths of the drug scene,' says Father McVernon.

"We calm the typical overreaction to drug usage by helping the audience to realize such simple facts as that Pope Leo XIII enjoyed an elixir of cocaine in his old age and that heroin has been a major problem here in New York — not since 1970 — but since 1915, when 100,000 users were counted."

Alcohol use hurts heroin treatment

PHILADELPHIA — One out of two heroin addicts is also an alcoholic — or shows signs of becoming one, according to a study conducted at the Eagleville Hospital and Rehabilitation Center here.

The study, funded by the National Institute on Drug Abuse, indicates alcohol abuse is the primary cause for failure in heroin treatment programs, and that it is the more emotionally-disturbed addicts who get into trouble with alcohol.

For these addicts, treatment should not be focused simply on treating their substance abuse in methadone clinics, without providing the kind of therapy needed to get at the underlying problems, said project director of the study, Harriet L. Barr at the 9th Annual Eagleville Conference on Alcoholism and Addiction.

(As part of the Eagleville study, 864 subjects are being followed for a year after they enter treatment for heroin addiction; 590 entering methadone clinics and 274 entering Eagleville, a therapeutic community).

Half of the heroin addicts studied drank amounts of alcohol usually associated with alcoholism. At the time they entered treatment, 24.2% had a history of past or current alcoholism, reporting hallucinations, tremors, loss of emotional control, family break-ups and career failures because of their drinking.

An additional 24.9% reported high use of alcohol along with their heroin use, although they did not report any symptoms of alcoholism.

Drug addicts likely to be among the 49% who would get into trouble with alcohol have more disturbed personalities, less happy childhoods, and less stable lives than heroin addicts for whom alcohol abuse is not expected to be a problem, reported Dr Barr and Dr Arie Cohen, assistant project director.

A survey of the 24.2% who admitted to problems associated with alcohol revealed:

- *Their childhood memories were unhappy;* 44% said someone in the house was violent; 24% said someone in the house had suffered a mental breakdown; 39% said their father was alcoholic; 37% reported a death of a parent or sibling; and 37% were beaten or sexually abused when they were children.
- *Their lives as adults show signs of instability:* 35% reported having no regular place to live; 47% said their major source of income was illegal; 86% had spent time in jail (56% were arrested six or more times, 37% were arrested one to five times).
- *They are more depressed, anxious, dependent on others, and resistant to authority.* They worry more — about money, jobs, sex, drugs, and life in general. Suicide was on the minds of 36% of the addicts and 20% had attempted suicide.

"This group of drug addicts are not good candidates for programs which focus narrowly on their substances without providing the kind of therapy needed to deal with their underlying problem."

A heroin addict who is also a problem drinker needs help restructuring his life. This includes supportive counselling, psychological and psychiatric intervention, vocational training and family therapy, she continued.

Although this multi-faceted treatment is more likely to be found in a therapeutic community setting, some methadone clinics provide the one-to-one counselling and supportive services needed by the alcoholic-addict, Dr Barr concluded.

Raising the drinking age will only help: MPP Jones

HAMILTON — Raising the Ontario drinking age to 19 won't solve a complex social problem, but it would create a social gap that would do much to eliminate drinking in high schools, says Terry Jones, MPP for Mississauga North.

He is responsible for the Ontario Youth Secretariat, which did a study on use and abuse of alcohol by youth, and made 31 recommendations in a report last April. Raising the legal drinking age to 19 was one of them.

Mr Jones told the Institute on Addiction Studies at McMaster University here that 97% of high school students are 18 and under. It is unlikely a 19-year-old in college or out working would be spending a great deal of time with high school students, and this would reduce the peer pressure to drink in high schools.

Rx for the aged--a little sex, a little alcohol

In minor tranquillizers there's nothing minor

MONTREAL — "I have heard old people say that they would never go into a long-term facility for the aged because there are two things that wouldn't be permitted — sex and alcohol.

"But I think that both of these things are effective agents, used in moderation in that old-age setting."

Psychiatrist Eric Pfiffer, who is head of The Center for the Study of Aging and Human Development at Duke University in Durham, North Carolina, added that alcohol should be employed — in small amounts — only as a minor tranquillizer or a social stimulant.

Dr Pfiffer, who was speaking at a McGill University/Douglas Hospital international psychogeriatric symposium continued: "One should remember that in that old person, one is dealing with a brain that is functioning on the edge of capacity. With respect to cortical function, alcohol is a mild sedative with a 'kicker' (effect) three to four hours later. So, if you are going to give a drink to an older person, the best time is mid-afternoon or at the cocktail hour. This will mean the individual will not be awakened at 2 am when the alcohol turns into aldehyde. Essentially, alcohol exerts an irritant rather than a sedative effect."

Dr Pfiffer said he has never seen alcoholism develop in the aged, aside from "symptomatic alcoholism" where alcohol is used to self-treat depression. Alcoholism in the aged, he felt, would be carried over from an earlier period in life.

The prescribing of any psychopharmacologically active agent to an elderly person, is not a minor act, Dr Pfiffer warned.

"The term 'minor tranquillizer' should be expunged from our vocabulary in geriatric medicine, because there is nothing *minor* about giving a *minor* tranquillizer or a *minor* antidepressant to an older person, even in *minor* dosage."

Dr Pfiffer added: "While I think that there are special issues and special problems in prescribing drugs to the aged, I find that (drugs) represent such an important part of our treatment approach, we must learn to use them judiciously. Without them, we would be able to do much less."

In pharmacokinetics, little research has been conducted concerning the aged. Research to date does indicate that important changes take place in the body during the aging process involving drug absorption, excretion, multiple drug interactions and behavior associated with drug regimens, he explained.

An elderly patient may be receiving a number of uncoordinated prescriptions from various physicians, said Dr Pfiffer, and may even borrow drugs from relatives to avoid the expense of purchasing his own.

For these reasons, Dr Pfiffer said physicians must learn to use a small number of drugs effectively in treating the elderly rather than relying on minimal experience with many drugs.

Remand and referral plan is helping drunk drivers

HAMILTON — An alcohol court pilot project in Hamilton has shown some success in rehabilitating chronic drunk offenders in its first six months of operation.

Instead of being given an option of a fine, those convicted have their choice of going to jail, or taking part in a rehabilitation program.

If they choose the latter, the case is remanded to a specific date some months away. At that time, if they haven't co-operated, they go to jail. During the remand, the offender must stop drinking, attend the agency to which he or she is referred, and try to get a job.

Of the 189 men and 29 women in the first six months of the "remand and referral" project, 36 are now working, 54 have stayed sober, 81 are drinking less, and six are on job retraining courses.

Judge David Steinberg of the provincial family court in Hamilton-Wentworth got the program idea from his juvenile court experience, where remands are given to see if attitude and behavior improve.

He told the 17th annual Institute on Addiction Studies at McMaster University that fines have no meaning to these chronic offenders. The remand system may work because "in the back of their minds they know they have to go back to the judge and explain why they didn't keep their part of the bargain".

He was astounded to find from pre-sentence reports how many of these offenders were taking alcohol as a pain-killer for injuries received in war, or in fights or accidents. Their use of alcohol lessened if they were given other pain-killers.

James H. Edmonds, coordinator of the project, said the availability of 15 agencies to which offenders may be referred accounts for much of its success. The agencies include in-patient and out-patient alcoholic services, half-way houses for both men and women, a detox centre, Salvation Army, Alcoholics Anonymous and Recovery Inc.

Average age of the first 218 people in the project was 37, with 5% below 18 and 37% over 45. Not all were alcoholics: some had suddenly taken to drinking heavily because of a particular situation, and with help, were able to get their lives straightened out and return to their formal responsible living patterns.

In spite of the adage 'you can't trust an alcoholic', Mr Edmonds said 182 of the 218 kept their appointments with the agencies to which they were referred.

"The alcoholic needs an excuse to drink, no matter how weak it is, like a rainy day. He also needs an excuse to stop, or he'll lose status with his peer group. If he can say the court told him he had to stop or else, it gives him an excuse to bow out."

Beer gets sheared by BC barber shop

By Tim Padmore

VANCOUVER — Until recently, "suds" at Mel Galbon's barbershop meant more than a shampoo.

Customers at the Headhunter's Den could, if they wished, indulge in a free beer or two while Mr Galbon snipped.

But the practice ended with a raid by the city police vice-squad. They told the barber he was violating a provincial law against drinking liquor in a public place.

Faced with the possibility of losing his business licence, Mr Galbon took the beer home and switched his customers to coffee.

"All that fuss over a few bottles of beer — it's really hard to believe," he said.

But to the British Columbia Liquor Administration Branch, it's an open and shut case: a barbershop is a public place, and its against the law to drink in a public place.

"It's as simple as that," said B. E. Munkley, LAB director of licensing, and added: "Boy, at the price they're charging ($12-$15 for a shampoo and cut), I can see how they can afford to give it away."

(A new liquor act introduced two years ago by the then NDP government, which allows some drinking in public places, such as parks, was passed by the legislature but has not yet been proclaimed.)

Mr Galbon said he doesn't plan to fight the ruling even though, he claimed, there are several downtown barbershops which carry on the same practice and some clothing stores which offer beer and even free cocktails.

He said he asked one of his lawyer customers for advice and was told there is no question his shop is a public place as defined in the law and he had better keep the bar closed.

So Mr Galbon's customers, some of whom have been enjoying free beer at the shop for as long as a decade, will have to be content with being trim but thirsty.

Attitudes hardening

Smoking declining

ATLANTA — Public attitudes favoring stronger action against smoking, coupled with a decline in the proportion of adult Americans smoking since 1970, are two findings of the largest survey ever conducted on tobacco use.

The survey of 12,000 men and women in the US, age 21-and-more, was carried out in 1975 by the division of Cancer Control and Rehabilitation, of the National Cancer Institute and Centre for Disease Control.

"The decline in the proportion of adult Americans who smoke, and concurrent increase in public attitudes opposing smoking demonstrate that Americans can change their life styles for the sake of their health," said David J. Sencer, director of the Center for Disease Control.

The survey, which was the fourth in a series conducted by the US government since 1964 also found that:

- the proportion of male smokers 21-and-more dropped from 52.8% in 1964, and 42.2% in 1970, to 39.3% in 1975;
- the proportion of female smokers 21-and-more dropped from 31.5% in 1964, and 30.5% in 1970, to 28.9% in 1975;
- both male and female smoking decreased proportionately in every age group, although there was a slight increase among women aged 21 to 24, women 55 years of age and older, and men 65 and more;
- declines between 1970 and 1975 were greatest among young males aged 21 to 24, from 49.8% to 41.3%; and
- in absolute numbers there were an estimated 875,000 more smokers in 1975 than in 1970.

A change in smoking attitudes was indicated in the responses to the statement, "The smoking of cigarettes should be allowed in fewer places than it is now." In 1964, 52% agreed with this statement; in 1970 the figure moved up to 57%; and in the 1975 response, 70% agreed with the statement.

Most of the current smokers (61%) have made at least one attempt to stop smoking, and although most of the smokers would like to quit, 57% reported they will definitely or probably still be smoking five years from now.

Men and women who are divorced or separated are more likely to be smokers than are people who are married, widowed, or single. For all marital categories, more men than women (proportionately) are smokers, the survey found.

Researchers also found a relationship between educational level and smoking behavior. Smoking rates are lowest for those who never attended high school.

Drug use patterns

Street users may provide important clues

By Tom W. Hill

MIAMI — An anthropologist here who researches drug use patterns on the *street level*, has found that substance users may provide helpful clues about the nature and extent of their own drug usage.

Patricia J. Cleckner, director of enthnography at the Center for Theoretical Social Research on Drug Abuse, division of Addiction Sciences, University of Miami, says her recent studies in the area of what she calls street pharmacology show that heavy substance users define drugs in ways that reveal a great deal about their relationship to society.

Patricia Cleckner

A former drug user, Dr Cleckner is at home with street language, and has been able to develop key contacts who supply information and introduce her to other people she may want to interview. The information (street material) she gleans in her interviews can then be used in developing hypotheses for further study.

Dr Cleckner found that more than half of a small sample of people who were either light users or non-users of drugs, included medicines in their definitions of drugs. But only four of 20 institutionalized users and dealers mentioned medicines in their definitions.

The two basic ways of classifying drugs, Dr Cleckner points out, are *medical* and *legal*. While the legal profession bases its classification on a substance's abuse potential, the medical profession classifies drug types according to therapeutic action.

In categorizing drugs, non-users mentioned aspirin, antibiotics, other non-narcotic analgesics and tranquillizers. But not one of the 20 heavy substance users included these medicines in their categorizations.

The institutionalized users differentiated among drugs in two general ways; by their legality, and by their mood-altering effects on a user. Individuals in this group were primarily preoccupied with the 'high' that occurs when a drug is taken, tending to classify the highs by terms such as 'stoned', 'ripped', and 'wasted', to indicate high, higher and highest.

When naming specific drugs and dividing them into appropriate groupings, heavy users tended to reflect their own experiences. For example, those involved with narcotics usually offered an extensive list of pharmaceutical opiates, Dr Cleckner explains.

Marijuana, alcohol, and some other drugs appeared on some lists but not on others. Half of the user group reported they considered marijuana to be a "weak drug", or "not a drug", or a "garbage drug like alcohol."

To the hard-core drug user, people who use only marijuana aren't "one of us." They noted that "even narcs (drug enforcement officials) smoke pot." Dr Cleckner feels that with the increasing trend towards decriminalization of cannabis, the use of this drug has diffused to populations that have little or no identification with other aspects of the drug user's world.

In further analyzing the responses of the heavy user group, Dr Cleckner was able to separate the individuals into four types. Three of these types, although differing from each other in certain details, shared a tendency to classify drugs by the kind of mood alteration they produced.

Type 1 users, all of them black in the sample studied, classified drugs into only two or three categories, sometimes omitting hallucinogens, the third category.

Type 11 users, a small group, added a fourth category. Type 111 individuals, all of them white, used a multiple classification that Dr Cleckner regards as indicative of extensive experimental use.

The type IV group classified drugs according to danger levels of illegality. Of the six members in this group, two were "old-style junkies" with extensive street experience and a considerable familiarity with the law. The remaining four were "new junkies" who had either maintained conservative, traditional roles through much of their career as users, or had led sheltered lives and had not experimented before using opiates.

"Kinds of drugs tell about kinds of users," says Dr Cleckner. "There is some justification for viewing the polydrug users as a coalition of user types which is the result of certain yet-to-be-measured diffusion patterns.

"These patterns are of two types: interaction with ghetto and psychedelic subcultures and incorporation of drug use by a larger segment of society. These users are not so alienated from the mainstream as their predecessors," she concluded.

Hospitals get drug manual

OTTAWA — The Department of National Health and Welfare is providing Canadian hospitals with an emergency treatment manual for drug crisis.

***Drug Crisis Treatment*, prepared in conjunction with the Canadian Medical Association, is intended for use by doctors and nurses when faced with acute cases of drug chemical poisoning.**

The manual, an extension of an earlier first-aid guide *Bad Trips, Freakouts and Overdoses*, is also being provided free of charge to all medical and nursing schools in the country.

The CMA will assist in an annual revision of the material in the manual, which has been produced in a loose-leaf binder form to ease revision.

Fetal alcohol syndrome

Alcoholic fathers also affect their children

By Jean McCann

ACAPULCO — If a father drinks heavily, he may cause birth defects or fetal death in his offspring.

This startling addition to existing information about the fetal alcohol syndrome — and the conclusion that father as well as mother may be responsible for fetal wastage and defects — was presented here to the World Congress of the International Commission for the Prevention of Alcoholism and Drug Dependency.

F. M. Badr, a geneticist at the University of Kuwait, and formerly at the Worcester Foundation for Experimental Biology in Massachusetts, reported:

• A clinical study at St Vincent's Hospital in Worcester, showed more birth defects in 52 families where the father was a heavy drinker as compared to 50 control families; and,

• numerous animal studies which correlate alcohol dosage with both spontaneous abortion and birth defects.

Dr Badr later told **The Journal** the birth defects seen in children of alcoholic fathers in Massachusetts "were very much like those seen in the fetal alcohol syndrome. We could not establish such a relationship between the drinking behavior of the father and spontaneous abortion, as we did in animals, but this might be in large measure due to the smallness of the sample size.

"We expect now to extend to a more extensive study, involving perhaps 2,000 families, in order to establish this."

Dr Badr said the findings in his animal experiments, however, were quite conclusive — as were studies with human cells.

"We actually cultured human lymphocyte cells in vitro, in different dosages of alcohol, and we found that when we exposed these cells to something like 150 ml of alcohol — about a glass or more — this did indeed cause chromosomal aberrations.

Dr Badr said the role of alcohol as a genetic mutagen was evident in his animal experiments.

When mice were dosed with varying amounts of alcohol, and then mated with virgin mice of the same inbred strain, the result was more birth defects in the most heavily-treated group.

The mutagenicity of alcohol was emphasized with the case of "a male treated with alcohol who was crossed to a female 10 days after the treatment, and the offspring had limb deformities and some deformities in the skull which were expressed as bulgings over the head."

Dr Badr noted the animal studies revealed certain periods of the spermatogenesis cycle were more vulnerable: "Our data suggest that two particular stages of spermatogenesis — spididymal spermatozoa, and late spermatids, are the most sensitive stages to the action of alcohol as far as dominant lethal mutation is concerned.

"Another important conclusion reached from this work is that the higher the dose of alcohol intake, the more severe is the effect produced in terms of intrauterine death, which is a typical finding for a potentially mutagenic substance."

There has been too little research in the area of genetic damage caused by alcohol — perhaps due to fear of finding out the truth, Dr Badr told the conference.

"The aspect of possible genetic involvement of alcohol on prenatal as well as postnatal life, and whether it would produce a wider range of genetic damage besides dominant lethal mutations, needs to be investigated much further.

"The latter type of mutation, dominant lethals, has been regarded as imposing no genetic hazards on man since they merely result in abortions."

"The incidence of spontaneous abortions in many populations is about 20%. Drinking has, therefore, to be considered as one of the significant factors which might contribute to this wastage of human lives."

The men involved in the study at St Vincent's alcohol clinic, were drinking at least four drinks a night, but the mothers were not drinkers. The two parameters tested were the frequency of birth defects and the incidence of abortion in the first trimester.

"This model of experiment does exclude any teratogenic effect as only sperm of the male has been subjected to the alcohol circulating in the blood of the treated individual, and it is the transmission of the damaged hereditary material of the sperm that usually results in either incompatibility of the conceived embryo, or interference with intrauterine development," explained Dr Badr.

"A survey of this nature, but on a much wider scale, coupled with working out a mathmatical model for analyzing the derived data, is inevitable to settle this matter, and reveal beyond doubt the role of alcohol in contributing to man's role in raising malformed or mentally retarded children, as well as pregnancy wastage.

"The major finding of our work is the detection of induced dominant lethal mutations. This particular type of mutation is usually attributed to gross chromosomal damage incompatible with cell survival and propogation."

Dr Badr said the technique he used to analyse data included the use of two biological systems. The first was based on detection of micronuclei in certain stages of maturation of red blood cells, comparing control and alcohol-treated groups in which chromosomal damage was shown with alcohol ingestion. The second biological system was the human lymphocyte culture technique in which blood samples from non-alcoholic individuals were treated with low doses of alcohol in vitro, and then incubated for 48 hours.

"Screening the first mitotic field of these cultures has revealed several types of chromosomal aberration which included chromatid breaks, isochromatid breaks, fragments, gaps, dicentrics, and translocations. These different types of chromosomal aberrations were present in a much higher frequency in the alcohol-treated cultures than in the non-treated cultures of the same donor."

Dr Badr said these findings should give greater support to those involved in the prevention and treatment of alcoholism.

"We scientists can provide and present information, and it is then the duty of (you) educators, counsellors, psychiatrists, sociologists and physicians to handle that information and to see that they are helping achieve the goal of alcohol prevention."

Babies with alcohol effect will increase with more drinking and better detection

ACAPULCO — Babies with fetal alcohol syndrome will increase in number because young women are "drinking more, and drinking earlier," the World Congress of the International Commission on Alcoholism and Drug Dependency was told here.

L. A. Senseman

L. A. Senseman, director of the mental health center of the Adventist Medical Center in Glendale, California, blamed the drinking increase in part on "lowering the age of drinking in some states to 18" and on "seductive advertising of the liquor industry".

He said the increase in the fetal alcohol syndrome, with its various physical and mental effects, may also result from greater awareness of its existence on the part of doctors.

Children with minor effects of the syndrome may now be recognized whereas formerly they would have been overlooked, he said.

Dr Senseman said a Medline computer search of the literature about fetal alcohol syndrome in the last four years yielded more than 50 articles.

Information obtained from the literature search showed mental deficiency was common, and the most serious result to the baby of the alcoholic mother. Psychomotor disturbances, or tremulousness, considerable retardation of height and weight, and an increased frequency of birth defects were common also.

"The effected children often fail to thrive in terms of survival, neonatal adaptation, brain function, and growth. There has definitely been an increase in perinatal mortality, and the surviving infants often have difficulty in adjusting to extra-uterine environment." At postmorten, recent findings have shown central nervous system malformations, he added.

Dr Senseman said alcohol is present in the tissues of the fetus at the same level as in those of the mother, as shown by tests on maternal and cord blood.

"One French doctor also reported that he could smell alcohol in the amniotic fluid, and also on the baby's breath".

Another unusual finding is that of distinctive palmar creases, he said. "It is interesting that this work has been duplicated in experimental laboratory animals, and suggests that the levels in the fetus are directly related to the level of unmetabolized alcohol."

Some of the authors, concluded Dr Senseman, "have postulated that a large number of less severely affected children of chronically alcoholic women who manifest only mild degrees of mental and growth deficiency" may have the syndrome. Such children may, for instance, have smaller heads or lower weight or height.

Starchy food and alcohol— artery disease warning

ACAPULCO — Women on high carboydrate diets should be careful about their intake of alcohol because of potential artery disease in the legs, according to US National Institute on Alcohol Abuse and Alcoholism director, Ernest P. Noble.

Dr Noble told the World Congress of the International Commission on Alcoholism and Drug Dependency here that studies in Italy link atherosclerosis in women with a high carbohydrate intake.

"These women have a problem with the arteries of the lower limbs," he said. "They have a great deal of trouble in walking. This appears to be directly related to the high food and alcohol intake, although these women are not drinking tremendous amounts of alcohol. I think they may drink only a half litre of wine a day."

Worried husbands cost money

By Betty Lou Lee

HAMILTON — If industry helped to uncover the hidden alcoholic wives of its workers, it might be to the companies' financial advantage, the director of a women's crisis centre suggests.

Marguerite O'Rourke of Open Arms Haven for Women and of Oakway Half-Way House for Women in Hamilton, says many companies have programs to detect alcoholic employees, and conduct educational programs on alcohol use.

Francoise Berthiaume

"But I wonder how many industrial accidents are caused by husbands worried about an alcoholic wife, or worn out by trying to cope with the situation? I wonder how much absenteeism is caused by men having to get the kids off to school, or getting her to hospital?

"I wonder if it wouldn't pay (companies) to educate employees about the alcoholic woman and where they can get help," she said at the 17th annual Institute on Addiction Studies at McMaster University.

That help isn't as available for females as it is for males, judging by her experience. She said although Hamilton needs a detoxication centre for women, few people will believe there is such a need. They wouldn't believe there was a need for a women's crisis centre and halfway house either, until she opened them and was swamped with requests for help.

"Female alcoholics are not recognized because they're not acceptable," she said.

She estimated that almost half of the local Alcoholics Anonymous members are women, but there are few husbands at meetings of Al-Anon, and few men seek help for their alcoholic wives. "Maybe they don't want to admit they may be part of the problem."

Francoise Berthiaume, executive director of the Canadian Foundation on Alcohol and Drug Dependencies, said that it is part of the stereotype about women drinkers to say they are sneakier and slyer about their habit.

They *are* drinking on the job she said. But for large numbers of them, that job is at home.

"It is less a matter of trying to conceal it than it is a matter of being socially assigned to a place where the drinking is not as publicly visible.

"The second factor is related to the differential in attitude our society has to drunkenness in females and males . . . you have to be pretty dumb, if you're a female alcoholic, to go out and make yourself as visible as possible."

Ms Berthiaume said women seem to "catch" alcoholism from their husbands more frequently than do husbands from wives.

For some women, the problem may start with early life experiences that result in their being dependent, vulnerable people who fantasize about marriage and then take to the bottle when faced with its realities.

Such a woman finds in alcohol a friend who is always there, available when she wants it without delay, and a source of disturbance to people around her. With that potent a weapon to fight back at a frustrating world, "it is a wonder we don't have more women alcoholics."

Ms Berthiaume recommended more research on the effectiveness of various treatment methods with men and women.

Although some research indicates male and female alcoholics differ, "these differences are not generally reflected in treatment programs. Treatment methods originally designed for male alcoholics are not necessarily effective in treating females."

One study indicated that women respond best to individual therapy, while men prefer group treatment situations, she noted.

In her 3½ years with Open Arms Haven, Mrs O'Rourke has found that women alcoholics in general have low self-esteem, have trouble communicating, are dependent on others, and don't know how to handle anger.

Police are having trouble with new legislation

HAMILTON — Ontario's new Liquor Licence Act is having some unforeseen effects.

Fewer people are being charged with public drunkenness, but more are being charged with other offences so police may get bothersome drunks off the streets.

Police are being taunted by youths and drunks waving open bottles at them, knowing they can't be arrested.

And the public is getting increasingly annoyed at the inability of police to remove drunks from public places.

The repercussions of the changed laws, which came into effect Jan. 1, were outlined by two Hamilton-Wentworth Regional Police officers at separate sessions during the 17th annual Institute on Addiction Studies at McMaster University.

Staff Sgt. Fred Pawluk of the vice squad said the region previously averaged 4,200 arrests for public drunkenness a year. This year the total will be about 1,000 fewer, because a person can't be arrested just for being drunk in public — he must be a danger to himself or other persons.

"So if a drunk is yelling at pedestrians, and he's not harming himself or others, how do you get him off the street? You arrest him for a criminal offence, like creating a disturbance.

"I don't know if this is good legislation or not. Perhaps for the derelicts it just adds to a long list of offences. But for the guy who goes on a toot once in a blue moon, it seems serious to give him a criminal record. The police officer lays the charge to solve a situation — he's under pressure to get the guy off the street."

Staff Sgt. Pawluk admitted that the situation may also tend to mask the public drunkenness problem in statistics, since drunks charged with criminal offences won't appear as such.

He said the "public is incensed" at the sight of motorcycle gangs and drunks flaunting open beer, wine, and liquor bottles at police. The public doesn't understand that under the new act, it is no longer an offence to have an open bottle in public, it's only an offence to be seen drinking from it.

"They're careful not to take a sip while we're watching," the officer said of those who taunt the police.

Constable Terence Sullivan of the crime prevention bureau said the new act may also mean a decrease in the number of alcoholics taken to detox centres. Under the old regulations, police could take someone to a detox centre rather than arrest him.

"However, I believe that if a person is going to be arrested for the protection of self or others, he will likely have to be incarcerated, or at least detained until such time as he sobers enough to be processed for release."

In 1974, 12% of those arrested for public drunkenness in the Hamilton region were taken to the detox centre, and that number was limited by available space. This year, he estimated, referrals will not reach half that figure.

The new act "allows the skid row drunk to roam about undisturbed . . . . . forces the public to bear with the inebriates who always seem to clutter the public parks and streets . . . . and (means) you can hardly walk in the public parks now without falling over an empty beer or liquor bottle," Constable Sullivan said.

Commenting on the reduced drinking age in Ontario, the constable said it has changed the whole hotel culture.

"It is my opinion that in comparing the turned-21 drinker of the past with the turned-18 drunker of the present, the latter has less control of himself emotionally and physically when drinking.

"The incidents of assaults on police by the youthful drinker have increased . . . . . I feel that the present age of drinking has to be reviewed seriously, for it may be time that the age was once again raised to 21 years."

Both officers noted that the mean age of the skid row drunk is becoming younger each year.

"We're getting more alcoholics in the 15- to 18-year-old bracket," said Staff Sgt. Pawluk. "By 18, some of them are literally skid row derelicts. We know 18 such alcoholics in the city now."

One positive change he saw in the new Liquor Licence Act was requiring a family court hearing before someone can be placed on the Interdicted List. Previously, police were often asked to make such decisions when wives made complaints about alcoholic husbands, "and I didn't feel qualified".

Constable Sullivan said the person can be placed on the list if by excessive drinking he "misspends, wastes, or lessens his estate, or injures his health, or interrupts the peace and happiness of his family". This could apply to 15% of the Canadian population, he added, but the Liquor Board's policy is to investigate thoroughly, and relatively few approvals are given.

Terry Sullivan

Trailers deliver doorstep drug info

HAMILTON — A trailer program that began in response to the drug crisis in 1970 has been converted to serve a broader purpose in helping Ontario communities understand their young people.

The trailers are now called Youth Information Centres, are staffed by young married couples, and spend a week or more of each summer in parks and plazas when they are invited into communities.

The program is conducted by Alcohol and Drug Concerns, Inc., but is concerned with more than chemical abuse problems. By inviting youth in to chat about their ideas, problems, and attitudes towards their communities, the trailer staff is able to make objective assessments, and suggest community services.

Paul Lemon, 23-year-old coordinator of the program, says it isn't a matter of telling people what they should do.

"A community has ultimately to solve its own problems. I look on the trailer as a catalyst, to make initial contact with youth, and to get a picture of them, then to bring adults and youth together to design a program suitable to their particular needs. We give them our experience, impressions, conclusions, perceptions, and suggestions."

There are now three trailers, operating at a cost of $500 each a week. A local sponsoring group pays $300 a week, and ADC supplies the rest.

Sponsors have included town councils, ministerial groups, and service clubs. Before a trailer arrives in a community, Mr Lemon contacts police, parks, recreation, and civic officals to explain the program and its purpose.

"Since we're not associated with any particular church, or the Y, or any other group in the community, young people don't attach any automatic connotation to us," he says. "This can be particularly valuable in small communities."

The trailer staff sends a written report to its sponsor after it leaves. In one community, its visit resulted in a place for young people to meet under supervision. In another, the police department named a liaison officer for youth. In some areas, trailer staff are able to tell young people about facilities and services they had no idea existed.

Roadside tests draw critics' ire

(from page 1)

While critics of the roadside tests argue this violates an individual's civil rights, supporters of the law, including federal justice minister, Ron Basford, argue that drunken driving is a grave and continuing threat to other drivers and pedestrians, and therefore requires this sort of legal approach.

Despite the 1969 breathalyzer test law, which involves police station testing, a 1974 federal transport department survey found as many as one in 12 drivers were legally impaired and about 25% of drivers interviewed in eight provinces had been drinking — this, despite the more than 100,000 convictions under the breath test law.

Another survey revealed that almost 40% of 1,725 traffic accident victims in five provinces in 1973 were driving while impaired.

Another part of the new roadside breath test law allows judges to grant conditional discharges to offenders who agree to treatment for alcoholism. Technically, a discharge means there is no conviction, although there is still a criminal record. There has been some concern already expressed about the adequacy of available alcoholism treatment facilities in many provinces.

In an ironic sidelight to the drinking driving problem, it has been observed that automobile injuries and fatalities in Ontario this year have fallen sharply, supposedly as a result of tougher enforcement of the breath test law, reduced highway speed limits, mandatory seat belt legislation, and a reduction in driving because of soaring gasoline prices.

But the reduction in fatal auto accidents has sparked a complaint from medical authorities who have grown to depend upon car fatality victims as a source of kidneys and other organs used in surgicial transplants. Surgeons are reporting a growing list of patients now awaiting kidney donors as Ontario starts to bring traffic accidents under control.

Health and social issues more important than legal

(from page 1)

than because of medical consequences which are severe but not necessarily catastrophic."

Awareness is also increasing of the serious health consequences of alcohol and tobacco use, he said.

"The direction we are going and need to go is to view substance abuse in terms of health and social consequences, to move towards eliminating legal distinctions between drugs, so eventually we have a situation where efforts are made to discredit equally use of heroin, tobacco, alcohol, and marijuana. And a situation where you provide treatment equally.

Peter Bourne

"The heroin addict should be treated the same as someone with lung cancer. Both are drug casualties and the person with lung cancer should not be viewed as more socially desireable than the person needing treatment for the effects of using heroin.

"I doubt we'll get a totally equal system. I don't think we'll criminalize or make illegal use of alcohol and tobacco. But, certainly we are going to bring heroin and marijuana closer in line so we tend to view them in the same light."

Earlier, in an address to the 27th annual meeting of the Alcohol and Drug Problems Association of North America, Dr Bourne referred to the recognition that the war against drug abuse is not one that can be won. "We're in a long-term battle and accept the idea, as we do with individual patients, that substance abuse is a chronic relapsing condition. We've learned not to look on it as an all or nothing.

"We have also demonstrated our ability to squander money remarkably."

Age matters in fatalities

(from page 1)

about 22 times the risk; for the 45 - 49 age group, again slightly higher to 22 times the risk; and the over 50 age group is about 39 times the risk.

The point of the study is that no matter the age group, drunken drivers run a significantly greater risk of a fatal accident than the average non-impaired driver.

The statistical catch, of course, is that the drunken driver on the road is very likely to hit a car with non-impaired drivers in it, thereby actually increasing the risks of death for everyone, drunk or otherwise.

If there was some way to eliminate the non-impaired fatal driver accidents from the statistics, the risks of death among the impaired drivers would be even higher.

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Comment By Anne MacLennan

Heroin-a global game

HONG KONG — She's French and her name is Marie. Her hair is a darkish red — a fashionable color in a fashionable cut — and her nail polish is still unchipped.

But, she's lying sick and pale above the busy streets of Hong Kong in a crowded little room where women are invited — perhaps allowed — to come and try to kick their heroin habits.

The centre is run by the Society for the Aid and Rehabilitation of Drug Addicts (SARDA). A social worker — one who works mainly with European women who come here ("No, we haven't had a Canadian yet") — is trying to talk Marie into staying.

But she is on the other side of the world from France and home and all she really wants to do is get back to the street and her boyfriend-supplier. If she insists, she'll be allowed to leave.

About an hour's drive from Hong Kong's Suzie Wong district and Marie's struggle — maybe — to get rid of her habit, is Tai Lam Centre for Women. It's part of the Hong Kong prisons department system and the only prison for women in the colony.

Here, with 100-odd other women lives Bonnie who is Chinese. She is 17 and pretty and shy and admits in halting English that if she looks fit it may be because in the few months she has been here she has gained about 16 pounds — enough to get her weight up to what it should be.

She's here because she's a criminal — a thief. She is also an ex-addict. For how long remains to be seen but at the prospect of leaving soon, her face, her eyes, brighten.

Whatever else Marie and Bonnie are, they are losers in an ugly international game with many players in many countries but few winners.

If they had read the newspapers this week, they might have read about three other losers — American drug couriers about to go on trial in a Soviet court on charges of smuggling 72 pounds of heroin through Moscow airport.

The three face up to 10 years in a Soviet prison, the papers say. While pleading guilty, one of the three apologizes — to his family, his friends, his country — for shaming them. And himself.

At the same time in Hong Kong, officers of the Royal Canadian Mounted Police are among top enforcement agents from around the world who have just torn apart a multi-million dollar heroin ring.

It isn't perhaps a good week for Marie, Bonnie, and thousands like them but, on the face of it, it's a good week for law enforcement.

And yet, heroin abuse is spreading.

Dr Peter Bourne, a consultant to the US Drug Abuse Council and a leading figure on the international drug scene, talked recently about the relentless spread of heroin addiction into Latin America, Africa, Europe, and Asia, and said it poses a serious threat to the future of many small as well as established nations.

We need to begin to see the problem as one which must be dealt with on a worldwide basis, said Dr Bourne.

Another international authority is H. David Archibald, formerly executive director of the Addiction Research Foundation of Ontario, for the past year on special assignment with the World Health Organization.

He calls drug abuse a moving target and says that in Hong Kong, in Burma, in Pakistan, in Thailand, in Europe — in some areas where there has never before been a major heroin problem — heroin abuse is increasing significantly.

"Opium production in Southeast Asia is not a factor isolated to this part of the world. To the hill tribe in Thailand, opium is a cash crop — one that finds its ultimate payoff in Vancouver and Toronto, Detroit and Hong Kong and Amsterdam.

"It is in our own very selfish interests to be concerned."

Like strands of quicksilver, heroin slips down to to touch the lives of people on every continent. Enforcement agencies grasp the illusive threads occasionally and may be grateful they've made some small contribution.

But, they can't touch the demand.

H. David Archibald again: "We mobilize law enforcement resources to protect us at our borders . . . but give little more than lip service to the needs for treatment, rehabilitation, research, and education, that would allow us to reduce the demand for drugs."

Many international efforts, he says, have gone into breaking up various opium and heroin trafficking networks. But, almost nothing of consequence has been done to alleviate the health and social conditions that prompt people to use drugs.

* * *

Three weeks after Marie left the SARDA centre in Hong Kong to return to drugs, the Alcohol and Drug Problems Association of North America held its annual meeting in New Orleans.

For the first time and in the form of its Recognition Award for 1976, it gave its official stamp of approval to prevention efforts.

Dr Helen Nowlis, the recipient of the award, is director, division of drug education, health, and nutrition, department of health, education, and welfare, Office of Education, Washington

She believes drug abuse may be motivated by a need for slow self-destruction and for the adult person to be safe the child must first be rescued. She believes in beginning at the beginning.

If education and prevention, along the Nowlis lines, got the attention, the funds, the support that has law enforcement, and on a global scale, it could only help . . . not Bonnie and Marie but their children, and the children of others like them.

"Guess we'd quit smoking if it didn't make us feel so glamorous".

Inside Science

Patricia Erickson *

IN NOVEMBER 1974, the Canadian government introduced a new cannabis law, Bill S-19. This marked the first time since 1923 that cannabis had been separated legislatively from the opiate narcotics and cocaine. This bill proposed to remove cannabis from the *Narcotic Control Act* (NCA) and place it in a special section of the *Food & Drug Act* (FDA) separate from controlled and restricted drugs. After discussion and modification in the Senate, Bill S-19 was forwarded to the House of Commons. Although it remains on the order paper of Parliament, it may die there at the end of this session. (The Journal, September).

To answer the question of whether this or any new cannabis law would *decriminalize* the offence of simple possession, we need to understand the concept of *criminalization*.

Criminalization can be seen as resulting from the process leading to a finding of guilt with respect to a criminal offence and the consequences which follow the assignment of guilt.

Decriminalization might be demonstrated by either a reduction in the severity of sentences awarded or a decrease in the number of criminals produced.

When changes in both measures are occurring at the same time, however, the degree of decriminalization would depend on the relative weighting of the two components.

To judge the likely impact of the bill which would move cannabis from the NCA to the FDA, the proposals may be examined in relation to past criminalization patterns of simple possession under the NCA. It is important to keep in mind that the proposed amendment, like the sections currently in the FDA pertaining to controlled and restricted drugs, would still create *criminal* offences. The same types of penalties (e.g. fine, probation, discharge) and the same broad police powers as found in the NCA (e.g. Writ of Assistance which confers the right to search dwellings) would still be in effect. Since legalization requires the removal of a prohibited activity from the reach of criminal sanction and the substitution of some form of regulatory controls, the new bill would not move cannabis in that direction.

In considering the possible effects of the proposed law on criminalization resulting from sentence, changes both in the law "on the books" and the law "in action" must

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Backgrounder

New treatment cures addicts' cravings

BARCELONA, Spain — Ten long-term drug abusers have apparently been completely relieved of their craving for drugs by combination therapy with two narcotic antagonists — alpha methyl tara tyrocine [illegible] also called born Cleveland Clinic psychiatrist who has been treating the addicts at the University of Barcelona Hospital since March.

The treatment not only cured the addicts of their craving records for abusing cocaine, morphine, heroin, and amphetamines for from three to 17 years.

Cleveland Clinic physi[illegible] now hope to get permi[illegible] test the double [illegible]

The Journal, June 1, 1976

Jean McCann talks to José Pozuelo about what he calls a "tremendous step" in the treatment of heroin addicts.

CLEVELAND — José Pozuelo, a dark-eyed, intense man of Spanish birth, is a regular commuter between his office here in the Cleveland Clinic, where he is a staff psychiatrist, and his other office in Barcelona, Spain.

Word of his work (**The Journal**, June) leaked out a little early to suit Dr Pozuelo, who only began his small pilot study on the use of two therapeutic drugs — alpha-methyl-paratyrosine (AMPT) and fusaric acid — this spring. But news of the discovery spread quickly after he spoke to a staff meeting at the University of Barcelona, telling how addicts had lost all craving for narcotics.

He first began his research into the actions of therapeutic drugs in addicted monkeys, about six years ago.

In an interview in his suburban home here, Dr Pozuelo agreed to give **The Journal** fuller details of the breakthrough:

On what kinds of addicts did you use your therapeutic drugs?
They were abusers of heroin, amphetamines, methadone, and other drugs, for a period of from three to 17 years. One example was a heroin addict who was mainlining up to one gram a day, and using cocaine and other drugs.

Did these addicts want to take part in the study?
They very much wanted to. They were all involved voluntarily.

What was your protocol?
We transferred the heroin-dependent patients to maintenance doses of morphine, so as to get the baseline requirement for narcotics for each patient.

Also, during the initial week, we studied catecholamine levels, urinary pH, and other constants. In those who were to be on AMPT, we wanted to alkalinize the urine to about 8, to avoid the crystalluria which has been reported with this drug.

After the baseline was determined, we then raised the doses of AMPT or fusaric acid, until they reached predetermined therapeutic levels, or until the patient lost his craving for the addictive drug. Starting doses of AMPT, in the first six patients we studied, were 50 mg/kg of body weight per day, which was increased gradually by 25 mg/kg every two days. The starting dose of fusaric acid was 5/mg/kg per day, given in four divided doses.

Morphine addicts were also maintained on morphine, until the dosage of AMPT was close to 80 mg/kg of body weight, or the fusaric acid was at about 10 mg/kg.

Amphetamine addicts were maintained on amphetamines until a therapeutic level of 100/mg/kg of AMPT or 15 mg/kg for fusaric acid was achieved, at which point the addictive drugs were withdrawn.

The patients have been maintained on the therapeutic drugs for varying lengths of time, because the correct time is still evolving. In the first 10 patients, I would say it is for about 10 days.

How long have the patients been off both hard drugs and the therapeutic drugs?
At this time, the longest is for several weeks.

Did all patients require about the same dosages of the therapeutic drugs?
In the fusaric acid, you could go from 700mg to 1 grams, and in the alpha-methylparatyrosine, the range is from nine to 12 grams. These are the usual ranges, given orally.

How did you decide which patient should get which drug?
We did this randomly, in these first 10 patients. The only exception was in one patient who had a renal stone. Since AMPT had been reported to cause crystals in the urine, we put that patient on fusaric acid.

Did you see any side effects?
We watched carefully for these, and proceeded very cautiously in the first three patients before increasing the dose. I thought maybe we would see nausea and hypotension. What we did see was a very mild hypotension in two of the patients on AMPT, and nervousness, and perhaps one case of depression — although this patient was depressed prior to taking the drug — on the fusaric acid.

Do you think these patients will need to come back for a "booster" later?
First of all, I know that what we have done here is not a vaccination, and it's also not like Antabuse, because patients can have the drug and a narcotic at the same time without any shock. Therefore, I am assuming they could take up the use of drugs again. That's why you also have to consider psychosocial rehabilitation of the addict.

What about cost of this treatment?
It is very expensive now, as we're doing it. About $500 a day. We hope to get a grant which will help with this, if we are able to do studies in the United States.

In your experience so far, which drug is the best?
Well, this is a very short followup, but in my experience the one that is producing less side effects, and which seems to be better tolerated, is the AMPT. In my animal studies, I thought the fusaric acid would be better, but no.

What are these drugs used for, ordinarily?
These are not something you can get in the pharmacy, although they were discovered some years back. They were used then for hypertension, but their effect was very mild, and so they did not get into clinical use. AMPT has also been used in other conditions such as pheochromocytoma and in Huntington's chorea, but in my opinion, always in mgh doses that were not big enough.

Then could you use other hypertensive drugs for this purpose?
We did use aldomet, but it did not produce any results.

How do you believe these new therapeutic drugs are working? Are they taking over opiate receptor sites, for example?
I am familiar with the work on receptor sites, but I have taken another approach. Rather I have taken an approach to treatment to see in what way the pools of catecholamines could be increased in morphine and in amphetamine addiction. Instead of influencing the receptor directly, what we are trying to do is perhaps influence them indirectly by manipulating the pool of catecholamines. Since both AMPT and fusaric acid interfere with the synthesis of catecholamines — what we are trying to do is to normalize the content of these brain hormones, by using these drugs.

Have there been studies showing in what way the catecholamine pools in a heroin addict, for instance, differ from those of a non-addicted person?
We are trying to do this exact thing, but we won't have the results for two to three years. First, we're working on treatment.

Where will you go now, with this study?
We are continuing the study, which is going on with the close cooperation between the Cleveland Clinic and the University of Barcelona, where it was officially presented. We hope this cooperation continues, because things can be done better in Spain, and I have had their entire cooperation. The Cleveland Clinic was also anxious to give their support, and their research committee, and human studies committee, and the board of governors, have been able to grasp the implications of this research.

Do you believe you have discovered the "real answer" to heroin addiction?
I think this is a tremendous step. You cannot redeem the addict while he has to fight the torture of continuous craving, or bear the suffering and unbearable pain of the withdrawal. I think this is a treatment which is effective in abolishing the craving for the drug, and the manifestations of the withdrawal. Also, the addicts are very anxious to be treated.

But one cannot suppose that one who has been a dealer for five years, or the one who is really incorporated into the culture of the addict, will not require a little more help of a psychosocial nature, in addition to the therapeutic drug.

Letters to the Editor

'Detoxes work'

To the Editor:

The Pennsylvania Association of Residential Detoxication Directors range in philosophies and milieus from social setting withdrawal units (the Toronto model) to modified medical units. The commonality we share is that houses are mostly residential in structure and are removed from institutional environments and settings. At least eight of our members including myself, emulate the Toronto model.

I am deeply indebted to the Addiction Research Foundation of Ontario for the research and development that went into the refinement of the houses. I am also extremely grateful for the

(continued on page 12)

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a first offence and $1,000 for a subsequent one. This reduces by $500 the maximum penalty now possible for first offenders under the NCA. While fines are a popular judicial choice for this offence, having been awarded in about 70% of all cases from 1970 to 1975, the actual amounts are not reported. However, indications are they rarely approach the maximum figure and likely average in the $50 to $100 range.

A related proposal, added in the Senate, was to make discharge automatic for first offenders. In 1975 fewer than one in four people sentenced for simple possession throughout Canada received a discharge, though more than half in Ontario did so. Thus, the substitution of discharge for conviction would have a greater impact in some provinces than others. Since discharge does create a type of criminal record, it remains to be established to what extent the consequences associated with discharge may be less severe than those for a conviction and fine.

• A third provision of the new bill would no longer permit jail sentences except in default of payment of a fine. The practical effect of this measure depends on whether people are still being sentenced to jail for possession. Such is indeed the case. While the proportion of jail sentences for simple possession of cannabis has declined steadily (from 46% of a total of 1,378 sentences in 1968 to 4% of 25,056 in 1975), the number of people being imprisoned has actually increased. Twice as many people were jailed in 1975 as in 1970. A jail term was the sentence in 1974 for 999 offenders and in 1975 for 1,094. Since the most severe consequences are associated with incarceration, the potential significance of this provision should not be underestimated. If the total number of sentences remained constant, a shift in sentencing patterns from jail to fines and discharge should have the effect of reducing the overall amount of criminalization.

This discussion suggests that the provisions in the new cannabis bill do represent, at least in theory, efforts to decriminalize the offence of simple possession by decreasing the severity of maximum penalties. In practice, however, most sentences being awarded under present legislation are well within the framework of the proposed bill. In many ways, the FDA amendment would do little more than recognize and formalize existing sentencing practices.

The most significant features of the bill, if it is reintroduced and passed, are those which would abolish imprisonment and make discharge automatic for first offenders. It must be considered, though, that the decriminalizing effect of these measures could be offset in two ways — if a large proportion of those fined went to jail for non-payment, and if the consequences of discharge, as yet undocumented, turned out to be no less harmful than those for conviction.

Thus far, the possible effect of the new law on criminalization through the number of criminals produced has not been considered here. While this is a difficult area in which to make forecasts, it can be suggested that the FDA amendment may contribute indirectly to an increase in charges and convictions. When drug offence penalties considered too harsh are reduced, the police may become more willing to charge, the crown to prosecute, and the judge/jury to convict. The result would be an increase in criminalization reflected by a rise in the recorded crime rate for the offence of cannabis possession.

In summary, the decline in severity of sentences for simple possession in the past decade has been accompanied by dramatic rises in the number of recorded offences. Thus, the total amount of criminalization imposed under the NCA may have been increasing.

The first apparent break in the spiral occurred in 1975, when convictions declined slightly in Canada overall, though not in every province. The new bill, if perceived by criminal justice personnel as "softening" penalties, could have the effect of inflating one aspect of criminalization — the numbers of offenders. At the same time, it could reduce the consequences to them by providing milder sentences.

Ms Erickson is a researcher in criminology with the Addiction Research Foundation of Ontario.

Israeli alcoholics

The number of people being treated for alcoholism in Israel has doubled since 1965, according to *The Jewish Chronicle*. The 1975 figure was 144 alcoholic patients, compared with 70 cases 10 years before.

Disco drinkers

Tequilla, also known as Mexican fire water, is catching on as the "in thing" to drink in the south of England. Promoters are concentrating their initial efforts in discotheques, suggesting cola and lime as the ideal mix.

Pay day play

The Papua-New Guinea Commission of Inquiry into Alcoholic Drink has told Courts to order that a wife, whose husband habitually drinks to excess, receive a portion of the cash wage of her spouse for the support of her children and herself.

Pale ale

Saudi Arabia has negotiated with an English brewery to purchase non-alcoholic beer, since Moslems are prohibited from drinking alcohol. The new brew will be made from hops, malt, sugar, and water, but the yeast will be omitted so that the fermentation process which produces alcohol will not occur.

Chronic alcoholism treatment

Behavior therapy may help at several stages

By Lynn Payer

PARIS — Behavior therapy may be useful at several levels in the treatment of chronic alcoholism, Dr Isidore Pelc, of the Psychiatric Institute, Hôpital Brugmann, Brussels, has said here.

Dr Pelc told the 10th International Psychotherapy Congress:

• Behavior therapy can help in the analysis of drinking habits, and in the modification of these habits by manipulation of environmental contingencies.

• It can help the severe alcoholic, who is frequently deficient in social competence, to acquire such competence, and

• it can teach self-control techniques useful in maintaining either total abstinence or controlled drinking.

Dr Pelc, who reported his experiences with a group of 12 alcoholics studied for more than a year, said there were several reasons which led him to consider behavior therapy for alcoholics.

"In the first place, drinking is, in fact, a behavior."

In addition, experimental psychologists showed some years ago that alcoholics are very sensitive to field dependency, Dr Pelc said.

"The clinical extrapolation of this notion would indicate the strong reactivity of these patients to the contingencies, and to modifications of their immediate and usual environment."

The "event excuse," where any situation becomes an excuse for drinking — "I drank because my wife left, because I lost my job, because I had problems, because . . ." — provides a good illustration, he added.

"We believe that in many alcoholics, these excuses merit more attention, and should not simply be seen as another reason to drink."

He explained that the 12 alcoholics who began group behavior therapy had all been pharmacologically dependent on alcohol and that most started the therapy following hospital detoxification. Eight were considered neurotic alcoholics, three habitual alcoholics, and one was both alcoholic and psychopathic.

The therapy sessions took place every two weeks, for 90 minutes.

In the first phase, each group member was called upon to name the elements connected with his drinking. This allowed the identification of certain danger states or danger situations that led to drinking.

If the alcoholic usually drinks in a cafe after work, he should be encouraged to change the usual routine — perhaps to propose a soft drink before he is offered an alcoholic one, Dr Pelc told **The Journal** in an interview. If this doesn't work, a more significant change — such as going to the movies after work instead of to the cafe — should be tried.

In the second phase, attention was directed towards behavioral problems that may have played a role in drinking and suitable therapy was initiated. For example, assertiveness training was taught to individuals lacking self-confidence, and exercises that would help the expression of emotions — particularly aggression — were used for individuals who drank partly because they had difficulty in this particular expression.

The third phase consisted of patients bringing back to the group the results of their experiences in the outside world.

Of the original 12 patients, two could be considered failures because they left the group against the therapist's wishes. Two more also left the group for individual psychotherapy. Of the eight who continued with the group, none had to be rehospitalized, with most abstaining from alcohol but two drinking moderately without loss of control.

Dr Pelc noted that predicting which group members could become controlled drinkers was extremely difficult. However, as patients experimented with drinking while they were still in therapy, failures could still be recuperated.

An advantage to behavior therapy, said Dr Pelc, is that since it is to some extent individualized, it would be applicable both in countries where alcoholism tends to be a habit, such as France, and in countries where there is a greater tendency for alcoholism to be the result of personality disorders, as in the United States.

Hungary takes firmer alcohol approach

MUNICH — Hungary is trying to come to grips with its rising alcoholism problem by restricting the sale of alcoholic beverages and prohibiting advertising.

Effective Sept. 1 there was a total ban on the sale or consumption of beer, wine, and spirits, either by the bottle or glass, in the cafeterias, canteens, snackbars and refreshment rooms of all Hungarian business, government, and educational institutions.

Simultaneously, a new decree issued by the Hungarian Ministry of Internal Trade in July, prohibits publicity or advertisements advocating the consumption of alcohol.

Until now, according to a 1972 law on the sale of alcohol, bottle or glass dispensation has been banned only in the canteens and cafeterias of factories, mines, and construction sites. Sale was permitted in the cafeterias and snackbars of business and government offices.

The legislation previously in force also banned the sale of alcoholic beverages in the vicinity of industrial installations, at athletic facilities, on public transportation and at railway and bus stations.

The measure is aimed at what Hungarians describe as "a rapidly spreading national disease."

According to recent findings by the Hungarian National Committee on Alcohol Consumption, there has been more than a 25% increase in the per capita drinking of Hungarians during the past eight years.

In 1968, per capita consumption was 7.8 litres of pure alcohol annually, in 1974 it was over 10 litres, and according to *Magyar Nemzet*, a Hungarian national daily, when the 1975 figures are compiled they will show "a 26% increase over 1974."

Hungarian sources place the country at the top of the world league in consumption of distilled spirits, in third place for wine, and fifth for beer.

It is now estimated that the country has 150,000 alcoholics in a population of 10 million.

Consumption has risen sharply despite price increases for most alcoholic beverages, and in Budapest this is ascribed to the dramatic improvement in the country's standard of living during recent years — a result of the introduction of the New Economic Mechanism, the Communist world's most effective system of economic reform.

Hungarian authorities have made various attempts to curb alcohol abuse and to combat alcoholism.

There is a total ban on driving after drinking and it is sharply enforced and observed.

When Hungarians go out in the evening to dine, knowing they will drink, they insist on going by taxi or public transport.

In 1974 the Hungarian government also passed a law calling for compulsory treatment of alcoholics.

The first of a series of "work-therapeutic detoxification" institutes was established at Nagyfa, near Szeged last year. It is capable of accommodating 1,000 patients.

NZ inpatient program working well

AUCKLAND, NZ — Fifteen percent of alcoholics treated in a 12-week inpatient program were apparently controlling their drinking two years later.

This proportion was in addition to an abstinence rate in 41% of the women and 29% of the men, said Robert J.M. Crawford, medical officer at Queen Mary Hospital, Hanmer Springs, which accepts patients on a voluntary basis from all over New Zealand.

Results in 313 alcoholics — the hospital's total admissions for 1971 — showed a success rate comparable with that for many serious medical and surgical conditions, Dr Crawford reported in the *New Zealand Medical Journal*.

He said all patients were offered the same program, involving education and the development of psychological insight through individual, group, family, and milieu therapy. Contact with Alcoholics Anonymous was vigorously encouraged. Use of disulfiram was encouraged but there was no aversion therapy.

Of the 262 men and 51 women, 43% of the men and 57% of the women were abstinent or 'improved' two years later. The 29% who could not be contacted were assumed to have relapsed.

Of those who remained for the full 12-week program, 47% of the men and 60% of the women were either abstinent or improved.

Abstinence was defined as not more than two short (less than one week) relapses during the first year and total abstinence during the second year. 'Improved' was used only where the patient's family or physician confirmed an improvement in drinking habits.

Dr Crawford said an alcoholic whose marriage or de facto relationship was intact at the time of admission was twice as likely as a single person to succeed in treatment.

Hong Kong establishes 12 ambulatory detoxes

By Lachlan MacQuarrie

HONG KONG — This community has added a new modality to its range of drug treatment services — 12 new ambulatory evening detoxification centres opened in June by the Hong Kong Medical and Health Department.

One of the main pressures on the Hong Kong government to set up the clinics has been the growing shortage of heroin and opium as a result of increasingly effective local and international control measures.

At a press conference to announce the opening of the 12 centres, Hong Kong Narcotics Commissioner, E. I. Lee, revealed that the street price of heroin in this British colony is currently averaging more than HK$3,000 an ounce (Cdn $600) which is 300% more expensive than it was two years ago.

"There is now the distinct possibility that addicts will turn to crime if they have no alternative supply," Mr Lee stated.

"The addict is now spending much more money on drugs than he did last year. Today he spends between $35 and $50 (Cdn $7 and $10) whereas as recently as the end of 1975 he was spending between $25 and $30 (Cdn $5 to $6) per day."

The situation has also been putting pressure on Hong King's treatment and rehabilitation facilities. With an estimated 80,000 to 100,000 heroin and opium addicts in its 4.5 million population, Hong Kong has places for about 1,500 of them in its compulsory treatment program, operated by the Prisons Department, and places for about 500 in the voluntary program operated by The Society for the Aid and Rehabilitation of Drug Addicts (SARDA).

In addition, the Medical and Health Department has been operating a methadone maintenance program in which four centres have treated a total of about 7,300 registered addicts with a daily attendance of about 2,500 patients. This represents a significant increase of about 2,000 in the last six months.

The 12 new evening methadone detoxification centres operate in regular government out-patient clinics, and are geared to serve addicts who would not be required by the courts to attend the compulsory prisons program, who would not be attracted to the in-patient drug-free environment program of SARDA, and who are motivated towards detoxification rather than maintenance.

The evening operation of the centres and their location in government ont-patient polyclinics is intended to help make attendance easy and anonymous.

In addition to the ambulatory methadone withdrawal, the centres provide medical examination and treatment as well as social work counselling and referral, if required.

Early indications are that the new detoxification program may be fulfilling its objectives.

In the first two weeks of operation the number of patients attracted has been more than 1,400. For the most part, these are addicts who have never been arrested and have never been known to SARDA or other rehabilitation agencies. Many are employed and some are reasonably affluent but they are nevertheless beginning to encounter difficulties as the price of drugs rises steadily.

The 'teeny boozer'

UK reports justify worst fears

By Alan Massam

LONDON — There are now unmistakable signs of a rising tide of problem drinking among young people in Britain.

The rebirth of the *teeny boozer* as headline writers have dubbed him, is marked by:

- a 36% increase in the number of prosecutions for underage (under 18) drinking between the years 1966-1973;
- a nearly threefold increase in the admission of under-25s to mental hospitals with a diagnosis of alcoholism (over roughly the same period); and
- evidence of an increasing number of under-14s found to have an alcohol problem.

These statistics were published in the annual report of Britain's National Council on Alcoholism as indicators of "unhealthy drinking among the young."

The council's director, Derek Rutherford, commented: "The onset of drinking is becoming younger and there is evidence that those who start younger tend to have a higher level of alcohol consumption."

[Mr Rutherford referred to a study by Major P.D.V. Gwinner, of two groups of alcoholics, one of males under 25 years of age, the other of males over 25. The study suggested that the . . "younger drinkers had rarely achieved a posture of social or normal drinking at all, whereas the middle-aged drinkers had enjoyed some 10 years of social or non-disruptive drinking prior to exhibiting alcoholic stigmata." The younger group of alcoholics (mean age 22.1) had lost control over alcohol consumption at an age 20 mean whereas the older group (mean age 35.9) had lost control at a mean age of 29.1]

Mr Rutherford added: "The explanation for the highly accelerated loss of control could only be the extremely large consumption of alcohol well in excess of that presented by the older group. The young group also exhibited a high degree of liver damage and a high incidence of alcohol-induced offences and alcohol-impaired driving."

The NCA director noted that since 1973, regional alcoholism centres had found about 20% of clients with severe drinking problems or alcohol dependence were under age 29.

He stressed the situation should not be exaggerated as many young people experiencing a drinking problem would check it and come to terms with alcohol.

"However, the pressures which mitigate against this must not be minimized," he said. "Young people are under greater pressure today to accept alcohol as almost a vital part of life. It can be said that we have arrived at the antipody of the situation 50 years ago. Drinkers, due to prohibitionist pressure, had to fight for the right to drink; now non drinkers have to exert their right not to drink. In a recent survey, 75% of self-defined problem drinkers claimed their condition was due to sheer social pressure and their response to conform to it."

Workers in the field are in little doubt that commercial interest in the spending power of young people has influenced their alcohol consumption.

Advertising has been unremittingly concentrated on the romantic potential of alcoholic beverages while many of the large and characteristically Victorian public houses in British provincial cities (as well as London) have been transformed to suit the tastes of the young. Transformation includes the introduction of discotheques and live rock bands.

One London social worker told **The Journal**: "The kids are attracted to the disco-pubs like flies to a marmalade jar. Of course, the serving of alcoholic drinks is not permitted to anyone under 18, but children of only 14 are allowed to enter the premises. Once they are inside it is impossible to say who is drinking what. Barmen can't be expected to ask for a birth certificate every time they serve a drink. In the halflight the age of the customer cannot be judged. Anyway, there is some evidence that not all barmen are as particular as they should be."

Anne Hawker, a worker with the Medical Council on Alcoholism, is conducting a study of British schoolchildren which suggests that the worst fears of field observers are justified. Prelliminary results from a comprehensive school in the county of Middlesex showed 33% of boys and 20% of girls at the school had their first alcoholic drink before their 10th birthday.

The survey, which covered children in the 13-16 age group also suggested that:

- Eight per cent of boys and 30% of girls "only drink on special occasions;"
- Thirty percent of boys and 32% of girls have an alcoholic drink at least once a month;
- Forty eight percent of boys and 30% of girls have a drink every week;
- Fourteen percent of boys and 8% of girls have a drink every day;
- Twenty-six percent of the boys and 33% of the girls said they had never had a hangover; and,
- Forty nine percent of the boys and 41% of the girls said they had had more than one hangover in the preceding year.

Mrs Hawker, said she had been surprised to find so many children in the 13-16 age group drinking "on a regular basis."

There is certainly no doubt that the school authorities are worried about the problem. *"The Disruptive Pupil in the Secondary School"*, (a report by a group of teachers and educators, edited by Clive Jones-Davies and Ronald G. Cave and published by Ward Lock Educational) found that alcohol was an important factor in disruption.

It said: "Children still at school who see drink as a symbol of maturity are frequent and sometimes heavy drinkers. A drunkard is difficult to handle at any time, but in front of a class of 14-year-olds the situation is difficult in the extreme. This is a problem new to schools and one that can only be dealt with in the short term by having the child returned to his home and his parents informed."

Kay Parry, a Gloucestershire comprehensive school teacher, says in the report: "Easy access to drink is one of the roots of the problem. This can be quickly and simply remedied by closing loopholes in the laws governing the sale of drink. For instance, drink should not be displayed on open shelves in supermarkets."

Mrs Parry suggested that advertisements for alcoholic beverages should be required to mention the dangers of drinking, but Bernard Braine, Member of Parliament and chairman of the NCA told **The Journal** that he was not in favor of such restrictions.

It would be unwise, he felt, for the dangers of alcohol consumption to be compared with the dangers of cigarette smoking (the manufacturers of cigarettes in Britain are obliged to publish a warning that 'smoking can be harmful to health' on the packs) because, taken in moderation, alcoholic beverages could be positively beneficial, whereas any amount of smoking was now regarded as harmful.

Sir Bernard is, however, concerned about the young drinker and was recently instrumental in securing the defeat of a proposal (the Licensing Amendment Bill) in the House of Commons that children under 14 be allowed unaccompanied in licensed premises up to 8 pm. The bill also sought to allow public houses to stay open until midnight.

Sponsors are now trying to persuade the Home Office (British Government department of home affairs) to reintroduce the bill as a government measure this month.

Rats kill themselves on self-administered methadone

PARIS — Rats that started self-administering methadone all kept steadily increasing their dose until they overdosed and died, Edward T. Uyeno of the Stanford Research Institute reported here.

Three of three rats that started giving themselves methadone by means of a permanently implanted jugular catheter activated by pressing a lever, overdosed within two to three weeks, he said.

A smaller percentage of rats administering cocaine or alcohol by the same means also overdosed and died, he reported, although none of the rats that self-administered morphine did.

Dr Uyeno said that the rats that self-administered methadone did so with steady increases in their consumption, without much day-to-day fluctuation.

"Some revealed slight cataleptic behavior soon after self-injection," he reported. "As daily consumption increased, the animals became more inactive and lay in an unusual manner with one side of the head on the floor and the tail stretched out."

This pattern of steady increase contrasted, to some extent, with the way in which the other drugs were self-administered, he said.

Rats self-administering morphine did so with daily fluctuations in the dose, although they gradually developed tolerance and increased their consumption.

"The daily intake levelled off approximately six weeks after the initiation of self-injection," he said.

Animals giving themselves cocaine tended to show a cyclic pattern, taking a relatively large amount during one or two days, reducing their intake considerably during the next three to five days, then starting the cycle again over a period of several months.

Those animals getting intravenous alcohol were first given 1% ethanol, which was gradually increased to 5%.

"Despite periods of voluntary reduction in self-injection, interspersed between days of high intake, the graph generally indicated a gradual increase in consumption," Dr Uyeno said.

He said the patterns of self-injection of morphine, of cocaine, and of alcohol by the rats were similar to the corresponding modes of self-administration by Rhesus monkeys.

As to what his results mean in terms of methadone maintenance programs, Dr Uyeno said that giving methadone is preferable to giving heroin, mainly because of its longer action.

Dr Uyno was speaking to the 21st International Congress of Psychology.

Martial law " a good thing"

Phillipine traffickers may be shot

ACAPULCO — The martial government of the Phillipines deals with drug traffickers — at least some of them — by firing squad.

And because the drug situation in that island country is now "under control" according to Phillipine doctor Ulysses Carbajol, "martial law has been a good thing".

"One Chinese trafficker responsible for drugs in Manila and even outside the city, was shot to death by a firing squad in the presence of the people." He added that a number of other traffickers have also been shot.

"I think that after this was done, the drug problem very substantially subsided.

"Before this martial law, about 50% or 75% of the students in the elite schools in Manila were using drugs, and now I think it is less than 10%. In the provinces, it is almost nil, "Dr Carbajol told **The Journal.**

He explained that jailed drugs users "are taken into prison, they're brainwashed, and many of them change their ideas."

Treatment for drug offenders in the island country includes time in a rehabilitation centre operated by the government.

"We now have about 1,000 offenders there, who are treated by eliminating drugs, and by being given good nutrition and vitamins. We do not use substances to substitute for the drugs, however, as is done in the US."

The Phillipines has been under martial law for four years. Dr Carbajol claims it is without bloodshed.

"I would say the country has progressed economically because of the martial law. Anyone coming to Manila now would see the cleanliness of the city, and the many banks and hotels sprouting. It's also more secure now. You can go out in a taxi, and not worry about heing brought to a place and robbed of your things. It's seldom heard of now, because anyone doing that would be shot to death."

Dr Carbajol, head of the eye department at Manila Sanitarium and Hospital, and chairman of the Phillipine Board of Medical Specialties was speaking to the World Congress of the International Commission on Alcoholism and Drug Dependence in Acapulco.

Doctors' orders?

LONDON — Patients in hospital, especially the elderly and those who are there for prolonged stays, should he able to have a drink at licensed bars within the hospital.

This recommendation from the Central Health Service Council to the Government said that for many patients a nightcap would be preferable to a sleeping pill.

Bill fails--UK children still banned from pubs

LONDON — Stauneh memhers of Parliament worried ahout Britain's rising rate of aleoholism, espeelally among the young, have in effeet killed a bill which would allow puhs to liberallze opening hours and admit ehildren.

Only if the Government devotes the time, whieh seems unlikely, will the Private Member's Bill by Conservative Kenneth Clark have a chanee.

Mr Clark's bill would have allowed pubs and eluhs to stay open until midnight and have admitted children to special rooms unaccompanied hy an adult. At present, children may enter pubs at age 14 but cannot he sold aleohol until age 18.

More Letters...

(from page 9)
hospitality I was afforded during the more than six weeks I spent since I first visited ARF and the detox units in March, 1974. I had the privilege of opening the first Toronto model in the Northeastern United States and am aware of what can and does happen in this type of milieu.

I am a believer in the axiom that anything that can be misunderstood will be misunderstood. I also believe in and recognize the need and value of research. Research, however, should also incorporate the use of multi-variable statistical analysis. Raw research can be very misleading when other variables are omitted.

We refer to the August, 1976 *AA Grapevine*, which reported on **The Journal** (May) article written by Gary Seidler — Detox System has little impact: ARF Study. *AA Grapevine* quoted in part: "*. . . Ontario multi-million dollar detoxification system is having little impact on the revolving door it was designed to replace . . . The detox and half-way house system may deteriorate into a new revolving door . . . .*" They are both erroneous conclusions that are not based on all the statistical information available.

For example (**The Journal** April, 1976), a series of articles by Betty Lou Lee, Halfway Houses Right on Target, and Hamilton Detoxification Centre is reeling off success stories, presents an entirely different set of statistics. Viewed from a purely economic standpoint, any detoxification centre which can reclaim 15 human beings in the course of a year justifies its existence. Hamilton reports, after a three-year experience, 148 former residents with a year of sobriety and 37 with two years or more. These statistics certainly do not by any measure signify failure, and these are only the reported findings of one detox facility out of 14 in Ontario.

If we continue in the area of economics, a halfway house costs $8.04 a day, and a detox bed costs $22.34 a day, versus the $32-a-day cost of jail confinement. We would suggest that treatment offered in a lower cost detox system, which recognizes and addresses itself to the respect and dignity in humanism, is more favorable compared to "the cycle of intoxication, arrest, trial, short jail term, renewed intoxication".

Can we expect an individual who has developed a life style of skid row living after three-to-10 years to completely reverse himself and develop immediate insights to the alternatives that are offered?

Research will show you that the second largest category in intake in large metropolitan areas after police referrals, are self-referrals. Further research into this second group will reveal that about 80% of this group are former police referrals. An assumption can be drawn that the treatment the chronic drunkenness offender received in the detox system was either more humane or less degrading, and rather than be arrested they presented themselves for treatment at detox centres. We view this same phenomenon in our residential detox facilities in Pennsylvania.

We must also ask what our social obligation or responsibility is to a human being who is sick, and cannot comprehend that the cure for his problem is the avoidance of chemical dependence on alcohol when his life style and present frame of reference blinds him to this reality.

Incarceration has not worked. The detox system is working.

Thomas M. Leis, President
Pennsylvania Association of Residential Detoxication Directors
Upland, Chester, Pennsylvania

'Pros and cons' reported

To the Editor:
While reading a critical letter accusing **The Journal** of one-sided viewpoint reporting, I felt moved to express my contrasting feelings.

As an educator having involvement with individuals cited for OVWI (operating a motor vehicle while under the influence of a drug) I have found **The Journal** an invaluable source in keeping abreast of the latest news/research developments.

I am impressed with your concept of reporting opposite viewpoints concerning an issue, in many instances side by side. This idea of providing available information pro and con in assisting the individual to arrive at his/her own educated conclusion is an important part of our program.

John Hammill
Group Dynamics Facilitator
Gateway Technical Institute
Racine, Wisconsin

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The Journal, published by the world-renowned Addiction Research Foundation of Ontario, is the international newspaper in the field of alcoholism and drug dependence. Each month, and more than ever, people in this field — doctors, lawyers, teachers, nurses, social workers, policemen, government officials, even private citizens — are turning to The Journal to keep in touch with what's happening.

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Brooklyn, New York

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CUT THIS ONE AND MAIL

New Books

by RON HALL

Mental Health Services in Developing Countries

. . . edited by T. A. Braasher, G. M. Carstairs, R. Giel, and F. R. Hassler

This volume contains 18 papers presented at a World Health Organization seminar on the organization of mental health services held in Addis Ababa in 1973. Concepts of mental illness, needs of the population, and the delivery of mental health care are described; and the planning of mental health services and the training of mental health workers are discussed. The book concludes with an evaluation of mental health services.

(World Health Organization — Information Canada, 171 Slater St., Ottawa, Ont. K1A 0S9. 1975. 123p.

Alcoholism: Inter-disciplinary Approaches to an Enduring Problem

. . . edited by Ralph E. Tarter and A. Arthur Sugerman

In this collection, the editors have presented discussions and reviews in the area of the causes, processes, and treatment of alcoholism with the objective of providing a perspective on the subject area. Various chapters outline a multidisciplinary framework, and many subjects, although not dealt with separately, are covered where they relate to the topics in a number of chapters. Included among the topics reviewed are; models and theories, medical complications, the female alcoholic, epidemiological and social factors. psychotherapy, family therapy, pharmacological therapy, and community programs.

(Addison-Wesley Publishing Company, Advanced Book Program; Reading, Massachusetts, 01867. 1976. 873p. $27.50 cloth, $13.50 paper)

Other Books

Methods in Narcotic Research — Ehrenpreis, Seymour, and Neidle, Amos, Editors. Marcel Dekker, New York, 1975. Drug administration, pharmacological effects, behavioral effects, tolerance, dependence, withdrawal, narcotic antagonists, chemical and biochemical techniques. 408p.

Brain, Behavior and Drugs — Warburton, David M. John Wiley and Sons, Toronto, 1975. Introduction to the neurochemistry of behavior. 280p.

Tales of the Ginseng — Kimmens, Andrew C. William Morrow and Company, New York, 1975. Folk tales, hunters of Taiga, European discoveries. 208p.

The Hasheesh Eater — Ludlow, Fitz Hugh. Level Press, San Francisco, 1975. 225p.

The Adventures of Sobriety — Stewart, David A. Michigan State University Press, 1976. Life styles, drinking patterns, reasons, sobriety, AA programs. 128p.

The Booze Battle — Maxwell, Ruth. Praeger Publishers, New York, 1976. Husbands and wives of alcoholics, employers, treatment. 192p.

Alcohol Use, Alcohol Misuse, Alcoholism: An Understanding for Nurses and Other Health Professionals — Crawford, Judy. Oklahoma State Nurses Association, Oklahoma City, 1976. Definitions, metabolism, sociological aspects, psychological aspects, phases, roles of the nurse, treatment, industry. 109p.

The Invisible Landscape: Mind, Hallucinogens and the I Ching — McKenna, Dennis, J., and McKenna, Terence K. Seabury Press, New York, 1975. 242p.

Standards for Drug Abuse Treatment and Rehabilitation Programs — Joint Commission on Accreditation of Hospitals, Chicago, 1975. Management, client service, continuity, research 105p.

The Influences Affecting the Increasing Use of Psychotropic Drugs — Especially by Women — Waghorn, Judith. University of Leeds, Leeds, 1975. 15p.

Project DAWN — United States Department of Justice, Drug Enforcement Administration, Washington, 1975. 23p.

Handbook on Evaluation of Treatment of Drug and Alcohol Dependent Patients — Pilot Alcohol and Drug Abuse Treatment (PADAT) Project. Veterans Administration, Department of Medicine and Surgery, Washington, 1976. Overview, procedures, evaluation forms. 40p.

Delinquency Amongst Opiate Users — Mott, Joy, and Taylor, Marilyn. Her Majesty's Stationery Office, London, 1974. Criminal histories, classifications, characteristics. 31p.

Use of Alcohol by Persons 65 Years and Over, Upper East Side of Manhattan — Johnson, Louise A. Mount Sinai School of Medicine, City University of New York, New York, 1974. Survey, drinking habits, sociological aspects. 156p.

A National Study of Adolescent Drinking Behavior, Attitudes and Correlates — Rachal, J. Valley, Williams, Jay R., Brehm, Mary L., Cavanaugh, Betty, Moore, R. Paul, and Eckerman, William C. Research Triangle Institute, Research Triangle Park, 1975. Design and methodology, demography, selected correlates. 390p.

Final Report on a Service-Wide Survey of Attitudes and Behavior of Naval Personnel Concerning Alcohol and Problem Drinking — Cahalan, Don, and Cisin, Ira H. Bureau of Social Science Research, Washington, 1975. Drinking practices, attitudes concerning prevention and treatment, comparison with civilian drinking. 210p.

Analysis of Drinking Behavior and Attitudes by Race — Cahalan Don, and Cisin, Ira H. Bureau of Social Science Research, Washington, 1975. Drinking behavior, naval drinking study. 24p.

Heroin Supply and Urban Crime — Drug Abuse Council, Washington, 1976. 16p.

Identifying the Problem Drinking Driver: An Evaluation of Some Psychometric Techniques — Crowe, James T. Jr. Mississippi State University, Mississippi, 1975. 62p.

Positions Available

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements, as early as possible, to: The Journal, 33 Russell St., Toronto, Ontario, Canada, M5S 2S1, or telephone, (416) 595-6053.

Canada

Ontario Hospital Association Annual Convention — Oct. 25-27, 1976, Toronto, Ontario, Information: Hillary Short, Ontario Hospital Association, 150 Ferrand Dr., Don Mills, Ont., M3C 1H6.

Ontario Occupational Health Nurses Conference 1976 — Oct. 27-29, 1976, Niagara Falls, Ontario. Information: Marjorie Gohm, Conference Chairman, Ford Motor Company of Canada, 9127 Montrose Rd., Niagara Falls, Ont., L2E 6X3.

Alcoholism and the Overseas Employee: Problems Facing Organizations with International Operations — Nov. 7-10, 1976, Toronto, Ontario.

Society for Neuroscience 6th Annual Meeting — Nov. 7-11, 1976, Toronto, Ontario. Information: Neuroscience Annual Meeting Office, 9650 Rockville Pike, Bethseda, Maryland, 20014.

US

2nd International Symposium on Alcohol and Aldehyde Metabolism — Oct. 16-17, 1976, Philadelphia, Pennsylvania. Information: Dr R. G. Thurman, 409 Anatomy-Chemistry Building, University of Philadelphia, Philadelphia, Pa. 19174.

Annual Meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism — Oct. 20-23, 1976, San Diego, California. Information: Pamela Maroe, ALMACA, Suite 410. Reston International Center, 11800 Sunrise Valley Dr., Reston, Va., 22091.

20th Annual Conference of the American Association for Automotive Medicine — Oct. 31-Nov. 3, 1976, Atlanta, Georgia. Information: James Fell, National Highway Traffic Safety Administration, N4E-32, 400-7th St., SW, Washington, DC, 20590.

1st National Conference on Issues in Juvenile Justice and Child Development — Nov. 14-17, 1976, McAfee, New Jersey. Information: Ronald Krate, Department of Psychology, William Paterson College, Wayne NJ, 07470.

3rd Annual Research Meeting: Alcoholism — The Search for the Sources — Jan. 26-28, 1977, Research Triangle Park, North Carolina. Information: Center for Alcohol Studies, Medical Building 207-H, Chapel Hill, NC, 27514.

National Drug Abuse Conference 1977 — May 5-9, 1977, San Francisco, California. Information: NDAC-1977, Haight-Ashbury Training and Education Project, 409 Clayton, San Francisco, Cal., 94117.

Abroad

Familie and Suchterkrankung — Oct. 4-7, 1976, Dusseldorf, Germany. Information: DHS, D-47 Hamm, Postfach 109, German Federal Republic.

4th Congress of the Comite National de Defense Contre L'alcoolisme — Oct. 14-16, 1976, Strasbourg, France. Information: International Council on Alcohol and Addictions, Case Postale 140, 1001 Lausanne, Switzerland.

International Conference on Alcoholism and Drug Abuse — Nov. 20-25, 1976, Baghdad, Iraq. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

7th International Conference on Alcohol, Drugs, and Traffic Safety — Jan. 23-28, 1977, Melbourne, Australia. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Cruising Medical Seminar on Alcoholism — Feb. 26-March 5, 1977, Caribbean cruise aboard Cunard Countess. Information: Center for Alcohol Studies, Medical Building, 207-H, Chapel Hill, North Carolina, 27514.

6th International Conference of the World Union for the Safeguard of Youth — May 31-June 4, 1977, Geneva, Switzerland. Information: World Union of Organizations for the Safeguard of Youth, 28, Place Saint-Georges, F-75442, Paris, Cedex 09, France.

23rd International Institute on the Prevention and Treatment of Alcoholism — June 6-10, 1977, Dresden, German Democratic Republic. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Surrogate opiates-- a way to conquer the first hurdle

By Avram Goldstein*

What are surrogate opiates? Is this just a complicated way of saying methadone?
Surrogate opiates are substitutes for heroin that are pharmacologically and legally better than heroin, and that are used as part of a comprehensive treatment plan. Methadone is currently the most widely used surrogate opiate, but the principle of surrogate opiate treatment applies to a variety of opiate drugs. It may turn out that different surrogate opiates are useful for different patients or at different stages of the treatment process.

What is the principal therapeutic aim in a treatment program employing a surrogate opiate?
The principal aim is to provide an opportunity for heroin addicts, who wish to end their addiction, to take the first essential steps without *at the same time* having a struggle with the physical, emotional, and psychological problems of withdrawal.

What is wrong with simple detoxification if an addict really wants to give up heroin use?
To give up heroin use (at least in our present society) is extremely difficult for most addicts. The basic reasons are not entirely clear; probably, there is a combination of social, psychological and pharmacologic reasons. We know when addicts are treated by simple 21-day detoxification, the great majority return to heroin use very quickly. Data indicate at least two-thirds of all addicts return to using heroin before the end of a 21-day detoxification, and 95% or more return to heroin within three months following detoxification. I do not argue that detoxification is useless. On the contrary, it is an important option to have available for addicts who wish to attempt instantaneous abstinence, or even just to reduce the size of their habits. But it is foolish, in view of the experience of the past 50 years, to suppose that we can cure addicts by simple detoxification alone.

Then what advantage does treatment with a surrogate opiate offer over simple detoxification?
Two major changes have to occur in a heroin addict before he can make significant progress toward a drug-free socially productive life. One change is the abandonment of heroin use — not partially, not sporadically — but totally. Unless this happens, relapse, sooner or later is inevitable. But, giving up heroin is impossible without the second change — the kind of change in life style that will remove the addict from friends and associates who are still enmeshed in the drug culture, and from the local environment in which heroin is freely available.

Alternative satisfactions have to be developed, in order to eliminate the craving for heroin. Experiences that are better and more satisfying than heroin use have to be built into a new behavioral repertoire. Self-image has to be improved. A new sense of worth has to be developed. The two major changes are interrelated, and they depend on each other. Without the life style change in all its ramifications (which I shall call *social rehabilitation)*, abstinence from heroin is virtually impossible. Without abstinence from heroin, social rehabilitation is virtually impossible. This dichotomy, in short, is why the reform and rehabilitation of heroin addicts has been so difficult.

The role of pharmacologic support with a surrogate opiate is to permit the immediate accomplishment of the first change (cessation of heroin use) in order to make it possible to work on the second change (social rehabilitation). By substituting another narcotic for heroin, the addict is immediately relieved of all the pressures to secure the illicit opiate. He is no longer required to obtain funds illegally for heroin purchase. Heroin can be stopped abruptly, without any withdrawal symptoms being experienced. Then the real work of social rehabilitation, treatment of disease, restoration of adequate nutrition, and so on, can begin. Brecher, in *Licit and Illicit Drugs* has put very well the necessity of giving first priority to social rehabilitation, withdrawal from a surrogate opiate being a secondary and later objective. The reason for the dismal failure of simple detoxification is — as I see it — that the detoxified addict, still driven by discomfort, physiologic imbalances, and intense craving, cannot focus attention on the needed first steps toward rehabilitation, but soon succumbs and starts using heroin again.

What are the special properties of methadone that make it a useful surrogate opiate?
Methadone has useful pharmacologic properties, but it is by no means the perfect surrogate opiate for all addicts. Its efficacy and reliability when taken by mouth means that for addicts willing to make the change, the needle habit can be broken. This in itself is an important step forward. First, it removes the addict from the life threatening consequences of unsterile intravenous injections, which lead so often to hepatitis, septicemia, abscesses, and serious internal infections. Second, it breaks the psychologic conditioning to the needle which, for some addicts at least, plays an important part in maintaining the addiction. Third, the regular ingestion of a surrogate opiate by mouth places the addict in the socially acceptable position of a patient drinking a prescribed medication, rather than in the surreptitious role of an outcast shooting drugs.

The duration of action of methadone is approximately 24 hours. This means that one daily administration of the medication suffices, breaking the pattern of drug-seeking behavior manifested four to five times daily. True, the addict feels the onset of early withdrawal discomfort every day before coming to the clinic. True also, the relief of this mild withdrawal discomfort continues the pattern of psychologic relief obtained from a narcotic drug. But what is reinforced thereby is not the hustling behavior of the street, but regular attendance at a clinic where ancillary rehabilitative services are provided. In this way, the dependence producing properties of the surrogate opiates help the patient to carry out the treatment plan of his own choice.

Another advantage of methadone (in contrast, for example, to heroin) is that it produces no overwhelming intense euphoria, the so-called rush. The reason is to be found in its oral route of administration, its slow onset of action, and its long duration of action. Of the two euphorigenic components in heroin's action, methadone has only one — the long-lasting, slow-developing narcotic effect that is identified by addicts as a feeling of repose, suffusing warmth, and relaxation. Even these, with methadone, are mild, and they tend to become less prominent as tolerance develops to the fixed dosage. Early in treatment the patient may feel 'loaded', but after a month or two this feeling subsides if the dosage is appropriately low.

What other surrogate opiates have a place in the treatment of addiction?
An important new pharmacologic agent is a derivative of methadone called levo-alpha-acetyl-methadol (LAAM). This surrogate opiate has a much longer duration of action than does methadone; 72-96 hours in most patients. It is also taken by mouth but owes its principal narcotic effects to metabolites rather than to LAAM itself. The effects of a single dose are very slow to develop, and the metabolites persist in the body for a very long time. Consequently, the drug produces virtually no high and no feeling of being loaded. Its sustained effect makes it possible to administer it three times weekly rather than daily.

LAAM has several advantages over methadone. First, the body is subjected to far less fluctuation of narcotic levels, so a more stable and comfortable maintenance results, which is more conducive to normal functioning. Second, the reduction in number of clinic visits makes it practical to operate treatment programs without any take-home medication, eliminating the grave problem of diversion, illicit trafficking, and accidental poisonings of innocent nonaddicts. Third, there are some indications of fewer unpleasant side effects.

On the other hand, morphine is a surrogate opiate that is very much like heroin and that might possibly find usefulness as a first step for addicts who are willing to initiate some changes in life style but are not yet ready to give up the intense pleasure of intravenous opiate use. I have proposed elsewhere (*Heroin Addiction: Sequential Treatment Employing Pharmacologic Supports*) a comprehensive treatment plan that employs morphine as the first of several surrogate opiates incorporated into a stepwise rehabilitation program with total abstinence as its goal.

Are ancillary rehabilitation services essential in a treatment program employing surrogate opiates?
It is possible that many addicts could rehabilitate *themselves* with the aid of pharmacologic support employing surrogate opiates. This possibility has never been tested in a well designed experiment. However, experience and common sense suggest strongly that most addicts do require professional and paraprofessional assistance of many kinds in accomplishing their rehabilitative goals. Even if no psychotherapy were available, there would still be need of medical and dental care, pragmatic counselling concerning ordinary life problems, assistance in dealing with law enforcement agencies, referrals for job training and education, and so on. Addicts have special problems of so many kinds that it is clearly more efficient (and more cost-efficient) to provide the necessary ancillary services within the treatment program, rather than expect the addicts to seek these out for themselves at numerous specialized agencies.

Is total abstinence the ultimate aim?
As an ideal to be worked toward — yes — but an all-or-none aim is entirely too pretentious, especially in view of the known quality of heroin addiction as a chronic relapsing affliction. The appropriate aim of a treatment program for heroin addicts — whether or not a surrogate opiate is used — is to assist in improving the conditions of the addict's life. *Problem reduction* is the realistic aim at every stage of treatment. Cure is certainly not to be rejected if it can be achieved, but outcomes short of cure must not be deplored as failures. If the conditions of an addict's life improve even slightly, he is better off than before, as is society as a whole.

Success is measured in small changes. A success is shortening a relapse and prolonging a remission. Success is turning a partial remission into a complete remission. As in the modern treatment of psychosis, we try to alleviate the acute disturbance and restore function, insofar as possible, using whatever means — pharmacologic and nonpharmacologic — are at our disposal.

Dr Goldstein is a professor or pharmacology at Stanford University in California, and director of an addiction research agency.

THE BACK PAGE

The Journal

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Addiction itself would be illegal

BC proposes compulsory addict treatment

By Tim Padmore

VANCOUVER — Health minister Bob McClelland has announced his intention to introduce legislation that would make heroin addiction illegal in British Columbia.

Mr McClelland told a meeting of the BC Corrections Association here he is hoping for legislation within several months that would require identified addicts to undergo some kind of treatment.

Bob McClelland

He agreed with a questioner in the audience who said that such a law would in effect make addiction itself illegal. (A user must now be found in possession of heroin to be come under the law.)

Defending the ethical acceptability of such a law, the minister said:

"As long as we give the user a voluntary choice of available treatments, then this direction of treatment is to me acceptable."

He cited the involuntary commitment of people for mental disorders and certain communicable diseases and said it is "crazy" not to use the same approach for heroin offenders.

The announcement had been expected by many in the drug addiction field. The government signalled its feelings this spring when it sacked the former Alcohol and Drug Commission, which had steered away from compulsory treatment, and appointed a new three-man commission headed by former Narcotic Addiction Foundation head, Bert Hoskin, who had been a vocal advocate of compulsory treatment.

Mr Hoskin re-iterated his position as a commissioner and is now, Mr McClelland said, preparing a report, expected in December, on how the compulsory treatment policy might be implemented.

In an interview, the health minister was vague about what kinds of treatment the addict might be offered.

"There are treatment centres all over BC, but they haven't been evaluated yet. That's one of the jobs of the commission. I don't think anyone has ever really been successful using a medical approach, but we've waited long enough. We could have studies for the rest of our lives, and we must take action."

He told the meeting he is opposed to a heroin maintenance program.

Reaction to the minister's announcement ranged from incredulity to cautious optimism.

David Berner, executive director of X-Kalay, a self-help program in which addicts take jobs within a network of X-Kalay businesses, was speechless for a moment and then burst out laughing.

"It won't work," he said. "It's not that I'm against compulsory treatment, but in this province, in this country, in this decade, it won't work."

He said the province won't be able to afford an elaborate custodial treatment program, and addicts will just walk away if they are sent against their will to open-door programs like X-Kalay.

He predicted the program would be no more effective than the province's Alouette River facility, a unit of the corrections branch which tries to dry out and rehabilitate alcoholics and which Berner described as a "circus" with the drunks promptly falling off the wagon, being picked up again, and being re-committed.

But Ray Cohen, director of the Alternatives program, which uses behavior therapy techniques to reform addicts, said his program (now funded by the federal government through the Non-Medical Use of Drugs Directorate) might work quite well within a compulsory system.

He said the nature of the

(See — BC — page 7)

This month

• *Industry and the alcoholic employee — correspondent Betty Lou Lee reports from the Quebec-Ontario Occupational Health Conference. Page 4.*

• *Ontario's detoxification system has come under heavy fire lately — findings of an Addiction Research Foundation of Ontario task force show the program's objectives aren't being met. For details see the Backgrounder, page 9.*

• *Although no lists of unsafe or safe drugs exist for a mother who breast feeds, a Canadian doctor says diazepam, lithium and certain others should be avoided. Page 3.*

Antabuse implants good for some

By Betty Lou Lee

QUEBEC CITY — The only two North American teams assessing Antabuse implants for alcoholics conclude it is a superior treatment for selected patients, but reactions to it are so different from reactions to oral Antabuse that it should still be considered an experimental procedure.

Investigators from Sunnybrook Medical Centre, Toronto, and University of Manitoba, Winnipeg, presented their results in a symposium at the annual meeting here of the Canadian Psychiatric Association.

In Toronto, when patients drank after having an implant, they reported headache, nausea, vomiting, and flushing, but the only observed reactions were flushing, sweating, and one case of palpitations. No one was hospitalized for a reaction.

Dr Stephen Kline, psychiatrist at Sunnybrook, said there was never a full blown disulfiram reaction, and results of drinking with the implant were "highly unpredictable".

Allan Wilson, PhD, psychologist in the department of psychiatry in Winnipeg, said the reaction noted there was far different from reaction to oral Antabuse. Its onset was gradual, over two to three days but sometimes up to two weeks, and it lasted two to three days.

"It was more like a severe flu, and patients were often bed-ridden".

Some Winnipeg patients got no reaction, others a mild one, and still others a severe one.

Dr Wilson said when the Antabuse implants were removed at six months in some patients, they were surrounded by necrotic fat or fibrous tissue with no blood supply, which might explain why some patients got no reaction when they drank. Efforts are being made to implant the tablets with as little trauma to tissue as possible.

The Toronto group has studied 200 patients with 339 implants over 2½ years, and Peggy Edwards, RN, said those who request a second implant are apt to do so because they say they can't trust their willpower and responsibility to take oral Antabuse every day. Others prefer an external control on their drinking, while still others consider they are "buying more sober time in which to rearrange their lives."

Some consider it added security for spouses or bosses, and a proof of their sincerity to try and rehabilitate themselves. They say their relatives don't expect them to return to helpless drinking,

(See — Antabuse — page 7)

But it isn't forgotten

Pot bill is dead: Lalonde

By Bryne Carruthers

OTTAWA — Despite the federal government's highly publicized focus on alcohol as a drug problem, health minister Marc Lalonde says Canada's long-awaited cannabis legislation is not forgotten.

During a news conference on his department's new alcohol advertising campaign, he admitted the cannabis legislation which has already been passed by the Senate and which had received first reading in the Commons, will "obviously die" on the order paper because a new session of Parliament is being started.

He said the bill would be reintroduced in the new session, but it is hoped it will not require a repeat of the lengthy debate and committee consideration in the Senate which took place during the last sessions.

While not saying when or with what priority the bill would be reintroduced, he did indicate that when it does happen, a version similar to that passed by the Senate would likely be introduced in the Commons to save time.

Interestingly, the government does not regard the cannabis legislation as important enough for it to attempt to obtain unanimous consent of Parliament to have the bill reintroduced at the stage of debate it had already reached in the old session. This approach is being taken with other legislation.

The cannabis legislation is intended to switch marijuana and hashish to the Food and Drugs Act from the harsher Narcotic Control Act. Simple possession would be decriminalized, with fines instead of jail sentences imposed. But, a criminal record would still result.

Outlaw round buying, say UK women

By Harvey McConnell

LONDON — The custom in British pubs of friends buying each other rounds of drinks is a root cause of many alcohol problems and should be banned, says a report from the National Council of Women.

The possibility of imposing a ban on round buying should be considered by the government. "It might be surprised at how readily such a ban would be accepted as we found it a source of embarrassment to many," the report adds.

The custom is that anyone entering a pub who accepts a drink from a friend or acquaintance is then obligated to buy a drink for everyone else in the group. This often leads to a social drinker's consuming more than he would like and it takes considerable courage at the start to insist on buying his own drink.

The practice extends often to regular customers buying drinks for bar staff. However, the customer never receives free drinks in return.

The National Council of Women, which is mainly a middle class body, issued the report following a year-long study and survey among its members.

The report says there are two main areas of concern in terms of alcoholism in Britain — women and teenagers.

The increase of drinking among married women is high. Many turn to drink because of intellectual boredom or because they are made "business widows" by the success of their husbands.

(See — Rounds — page 7)

Prevention is a necessity: Noble

NEW ORLEANS — Like their counterparts in Ottawa, US government officials want to change individual lifestyles and attitudes in order to prevent the growing "crisis of alcoholism".

"There is no doubt the crisis will worsen if we do not address ourselves to prevention," says Ernest Noble, director of the US National Institute on Alcohol Abuse and Alcoholism. "But we must resist the temptation to pass up approaches which lack the allure of the exotic and the highly sophisticated.

"We should concentrate first on the simple matter of strengthening those restraining elements which have always been present and available within each segment of society. We must find ways to help each individual apply his own cultural set of brakes."

As part of this education process, Dr Noble told the Alcohol and Drug Problems Association of North America here, those involved in alcoholism prevention may have to lean less heavily on negative information and get more deeply into subtle influences which abound in daily life.

"We should be asking, for example, if the media stimulate tendencies to consume alcohol or to drink to excess.

"I can't say at this point that the show business comic with his 'drunk routine' is doing harm. I can't say that the inclusion in virtually all films of social drinking episodes involves any risks. I can point out, however, that the concept of responsible attitudes about alcohol use requires us to help people focus on those values which enhance dignity and well-being within the culture or community in which we function."

The next step in this approach is an investigation of ways in which social and cultural constraints can be used to insure that elements within society bolster, rather than weaken, efforts to achieve responsibility in drinking behavior.

Dr Noble said the NIAAA is now considering "just exactly what these means are and the identification of appropriate programming to implement them".

"We have reached a point where necessity dictates delivery of something better than we have provided in the past."

To emphasize the "point reached" in the US, Dr Noble outlined some of the costs associated with alcohol abuse:

Ernest Noble

- The economic cost of misuse of alcohol is estimated at $25 billion each year. Of this $9.4 billion is attributable to lost production, $6.4 billion to motor vehicle accidents, $8.3 billion to alcohol-related health and medical problems.
- More than $600 million is spent on diagnosis, treatment, rehabilitation, education and prevention.
- More than $500 million is spent in components of the criminal justice system.
- Alcohol is the most abused drug among adults and teenagers in the United States, and the proportion of American young who drink has been increasing to the point where it may be designated as universal.
- Among American Indians, alcoholism is at an epidemic level. A conservative estimate of involvement is 10% — twice the national average.
- Yet another element is the increased use of alcohol in connection with other drugs — some of which are illegal.

Neuropsychological impairment in 40%

Polydrug use is high, will increase

QUEBEC CITY — About 40% of polydrug users will suffer neuropsychological impairment with prolonged abuse of sedatives and opiates, a multi-centre American study shows.

Follow-up studies three months after treatment demonstrated continued cerebral dysfunction, in spite of lowered drug use.

Results of the study were presented at the annual meeting of the Canadian Psychiatric Association by Kenneth M. Adams, PhD, psychologist in the department of psychiatry, McMaster University and Hamilton Psychiatric Hospital. He was involved in the study before moving to Canada from the U.S., and has continued to be the project analyser.

The eight-centre study is financed by the Polydrug Research Program of the US National Institute of Drug Abuse, and involves 151 polydrug patients in treatment at the centres.

In an interview with **The Journal**, Dr Adams said that based on incidence studies, 2,000,000 Americans and 200,000 Canadians are using too many drugs. "And it's my own opinion that if anything, it's going to be getting a little worse . . . . A lot of people may slide into it without realizing they are taking too many drugs for too many things."

The subjects in the study used primarily central nervous system depressants: ethanol, seconal, nembutal, and phenobarbital, rather than psychiatric drugs.

Dr Adams described their effects as "limiting the users' ability to cope with and adapt to the everyday world."

"This group isn't old enough for the classic alcoholism symptoms. It really begins to look like what we have is a mild, permanent deficit they've inflicted on themselves, and we're not sure we can do anything about it like we can for personality problems."

The subjects were not primarily those using street drugs or living in a drug sub-culture.

One example Dr Adams cited was a master plumber who had been drinking heavily for a long time, and added Mandrax for five years. "Combined, they were just dynamite." He developed hand-eye coordination problems that didn't improve after treatment, and could no longer work as a plumber because he was making serious mistakes that led to accidents. "His visual searching was inefficient."

Another subject was a public health nurse in her early 30s who developed a Talwin habit as a result of overwork and personal problems. After regularly taking 1.5 times the recommended maximum dose and also using a lot of alcohol, she developed hot and cold spells and numbness.

Subjects were excluded if they had ever had neurological illness, brain trauma, or brain surgery. They were compared to a group of psychiatric patients and normal controls matched for age, sex, and socio-economic factors, and given a battery of tests including tactual performance, memory and localization, rhythm, speech-sounds perception, finger oscillation, aphasia screening, sensory perception, tactile form recognition, grip-strength, Wechsler intelligence and MMPI. The tests were done three weeks after admission to treatment while the subjects were not toxic from drugs or in withdrawal, and repeated at three months.

"Polydrug subjects remained significantly less efficient on verbal fluency, abstraction, and problem solving measures, (and with psychiatric patients) showed poorer performances on spatial and tactile tasks."

One implication of the results is that impairment may limit the usefulness of verbally-oriented psychotherapies with this group, Dr Adams said.

The characteristics that define the polydrug user at greater risk for cerebral dysfunction include a man or woman over 30, with less than a high school education, and personality problems that are a manifestation of long-standing maladjustment to stress and life's demands. He or she uses a small number of drugs in the sedative and opiate groups, and has a long history of sub-rosa, non-medical drug use.

A mean drug use calculation for the three study groups over 10 years showed the pure ethanol consumption as 208,614 ml each for the polydrug group, 42,577 for the psychiatric group and 47,244 for the normals.

Central nervous system depressants, all converted to the equivalent of pentabarbital, totalled 562,600 mg for polydrug users, 9,200 for psychiatric patients, and none for normals.

The 10-year tally for CNS stimulants, converted to dextroamphetamine, was 69,940 mg for polydrug users, 180 for the psychiatric group, and 280 for normals (due to high use of diet pills.)

There was little use of hallucinogens — five 'hits' over 10 years for the polydrug group, none for the others. But the polydrug subjects were also relatively heavy users of cigarettes, marijuana, hashish, and narcotics. They smoked 3,191 packs of cigarettes during the 10 years, compared to 1,198 packs for the psychiatric group and 911 for the normals.

Dr Adams said the relationship between impairment and opiate use found in the study "is somewhat surprising and has not been previously reported. Heavy use of these substances may create impairment, or may worsen pre-existing deficits. It is also possible that previously impaired individuals may prefer these drugs, and use them in order to cope with stress . . . . but this seems unlikely."

Co-authors of the report are Dr Lewis L. Judd and Dr Igor Grant, department of psychiatry, University of California, San Diego; Albert S. Carlin, PhD, department of psychiatry, University of Washington, Seattle; Phillip M. Rennick, PhD, department of psychology, Lafayette Clinic, Detroit; and Dr Kenneth Schoof, department of psychiatry, Wayne State University, Detroit.

Tougher times for drivers?

TORONTO — Ontario's drinking drivers are in for a tougher time if some members of the provincial government's select committee on highway safety have their way.

The committee members want the level of alcohol at which a driver is considered impaired lowered to 50 from 80 milligrams of alcohol in 100 millilitres of blood. The MPPs also said jail sentences should be mandatory for anyone with more than 150 milligrams.

On their return from a fact-finding tour of Britain, The Netherlands, and Sweden, most committee members said they were impressed by the severity of the Swedish system and were prepared to recommend aspects of it in their upcoming report. (The committee's interim report, originally expected Sept. 30, is now scheduled for mid-November. Its final report will be made about next March.)

Although the committee seems to favor stricter penalties for drivers, it wants a rehabilitation scheme to accompany any punitive measures. For example, in the case of alcoholics it would recommend treatment rather than jail terms.

One man, one mouse, and their place in history

By Wayne Howell

IT WAS a wee, sleekit, cow'rin', tim'rous beastie, no doubt about that, and O what a panic was in its breastie, for I had just injected its abdominal cavity with what was normally considered to be a fatal dose of the convulsant metrazol. The year was 1963 and I was a student of pharmacology.

If the mouse could have spoken at that time, no doubt it would have had some words to say on the subject of man's dominion having broken Nature's social union and it certainly could have spoken with authority since a goodly number of the mouse's compatriots lay dead on the surface of the lab table — victims of my previous injections.

But this mouse was of special interest to me. Unlike the others, this one, and the ones in the series to follow, had been primed for their metrazol with an injection of Diazepam, a new drug stamped 'for experimental purposes only'.

That mouse did survive the convulsion, as I recall; in fact, all the Diazepam-primed mice save a few did quite nicely as opposed to the phenobarbital-primed mice and the chlorpromazine-primed mice. At the end of the simple experiment (which was conducted not so much in the interests of the advancement of pharmacological science as in the interests of demonstrating to students how pharmacological science was advanced), a significant percentage of the Diazepam-primed mice were scampering about the table apparently none the worse for their experience. And not, apparently, harboring in their little rodent brains grudges against me, their poor earth-born companion an' fellow-mortal, for having put them through their paces. And so, I wrote up the experiment, concluded that Diazepam was a good anti-convulsant in mice, and promptly forgot it.

Not too long after that, Valium was released on the North American market as an anti-convulsant, muscle-relaxant, and tranquillizer. Great things were expected of this younger brother of Librium. I never thought of that mouse again, not even when four or five years later people started to ask me for "Roche Fives", as casually as they would ask for aspirin, and showing me their expired prescriptions for 50 or 100 tablets. Not even when circumstances found me pumping stomachs with some regularity and discovering that the fluid that came grudgingly up through the plastic tube was more often than not stained yellow because of Roche Fives rather than because of a minor regurgitation of bile. Not even when Vivol, Anxium-5, Canazepam, D-Tran, E-Pam, Meval, Novodipam, Paxel, Neo-Calme, Serenack, Apaurin, Eridan, Lembrol, Noan, Setonil, Tranimul, Vatran, and all the other 7-chloro-1,3-dihydro-1-methyl-5-phenyl-2H-1, 4-benzodiazepin-2-ones appeared.

In fact, I never thought about that mouse again until recently when I read that according to statistics collected by DAWN (the US Drug Abuse Warning Network) Diazepam is now the second leading drug of abuse in all drug mentions in the DAWN system.

Why did I think of it then? Well, in retrospect, I wish that as that surviving mouse and I stood contemplating the dawn of a new pharmacological age, the age of Diazepam, I had quoted a little Robbie Burns to it:

But, Mousie, thou art no thy lane,
In proving foresight may be vain:
The best laid schemes o' mice an' men
Gang aft a-gley,
An' lea'e us nought but grief an' pain
For promised joy.

(Wayne Howell is an Ottawa physician and freelance writer.)

Although safe and unsafe drugs for nursing mothers are difficult to define, drugs containing diazepam, lithium bromides, reserpine and opium alkaloids should be avoided according to a Canadian doctor.

Breast feeding must hinge on mother's medications

QUEBEC CITY — It is difficult to prepare lists of safe or harmful drugs for the breast-feeding mother, but drugs containing diazepam, lithium, bromides, reserpine, and opium alkaloids should be avoided, says Jambur Ananth, director of psychiatric education and research at St. Mary's Hospital, Montreal.

Caution should also be exercised with barbiturates, haloperidol, and penfluridol, he told the annual meeting of the Canadian Psychiatric Association.

Knowledge in this field is very limited, and in all suspected or unexplained reactions in breast-fed babies, maternal drug history should be a priority, and breast-feeding should be stopped temporarily.

"Most drugs are excreted in milk in small quantities but this fact cannot be too comforting because of the possibility of cumulative effects, slow or absent detoxication, enzyme induction, and limited excretion in the neonate. In addition, even though side effects are not apparent, at least in animals it is noted that certain subtle behavioral problems occur."

If a mother requires prolonged medication, especially with drugs known or suspected to be dangerous, she should be advised to bottle feed the baby. For a drug not known to be dangerous, strict vigilance should be kept over the baby, and no medication should be prescribed for lactating women unless it is definitely needed, Dr Ananth advised.

Analgesics, antibiotics, narcotics, sedatives, tranquillizers, anticonvulsants, antihistamines, laxatives, diuretics, and oral antidiabetic agents in therapeutic doses pass into breast milk in undetectable amounts, or in concentrations too low to be toxic, Dr Ananth said. "Morphine, codeine, atropine, and scopolimine do not enter breast milk at all."

Concentration in milk depends on the concentration in the mother's blood, lipid solubility of the drug, and its degree of ionization.

"Infants' immature renal and hepatic function can delay excretion or inactivation of drugs, so that continuous output from mother's milk could lead to clinically important concentrations of some drugs in infant blood. In addition, since the intestine of the new-born permits absorption of undigested micromolecules, the breast-fed infant may become sensitised to trace amounts of drugs in the milk." Lowered renal function in the mother may also mean higher concentrations of drugs in her milk.

While side-effects in infants are rare, there may be more subtle, long-term effects, such as interference with normal developmental patterns.

Drunkenness in the mother can produce drunkenness in the breast-fed baby, but moderate amounts of alcohol do not appear to have adverse effects. "Social drinking cannot be treated as taboo in the nursing mother. Common sense should dictate that excessive drinking is to be avoided."

Alcohol cuts sex hormone

BOSTON — The first direct evidence that drinking alcohol reduces production of testosterone in non-alcoholic males, has been uncovered by a group of New York researchers.

Testosterone, the male sex hormone, governs such characteristics as sperm production, and facial and body hair etc.)

In a report in the *New England Journal of Medicine* (Oct. 7) the researchers said 11 male volunteers were each given a little more than one ounce of alcohol every three hours "around the clock" — not enough to make them drunk. All were given enough to eat.

Testosterone in the blood was measured in four of the men 24 days after the start of the drinking. In three, the concentration had fallen by 29% to 55%. The fourth man quickly developed an upset stomach and his alcohol intake was cut by two thirds. His testosterone stayed normal.

Two other men were tested at the fifth day. In one testosterone had fallen by 27%. In the other it had fallen only slightly.

The researchers, headed by Dr Gary Gordon of New York Medical College, said all six men were social drinkers, normally consuming no more than 2.7 ounces of alcohol a week.

Other hormonal changes seen in patients with alcohol-induced cirrhosis were not seen in the normal subjects. The researchers suggested that more chronic exposure to alcohol for a period of months to years might be necessary to produce these changes.

In an editorial commenting on the work, Dr David Van Thiel and Dr Roger Lester of the University of Pittsburgh School of Medicine said "the clinical effects of alcohol ingestion on male sexual functioning are overt. Corresponding changes in women may have a more subtle function." They added that they have no result yet from studies of women and alcohol.

Alcohol workers still have a choice

NEW ORLEANS — External regulation of the alcoholism service delivery in the United States is a distinct possibility.

But workers in the field still have a choice.

"We can either resign ourselves to increasing governmental or other external regulation and management of our activities," says Uwe Gunnersen, "or we can rapidly make the basic structural reforms necessary to make the alcoholism field more self-regulating in the public interest."

Speaking to the meeting here of the Alcohol and Drug Problems Association of North America, Mr Gunnersen repeatedly emphasized the need for more quality assurance in alcoholism programs.

"Unlike organized medicine we cannot demonstrate the quality of either our personnel or the structure, process, and outcome of our services. We mistakenly deal in fairyland statistics that vaguely describe the number of services delivered, when we should be actively developing or adapting and implementing peer review mechanisms that evaluate the quality of our services, our accountability to the client and his fiscal guardians, and the performance of our ethical and moral obligations."

Mr Gunnersen said when the US National Institute on Alcohol Abuse and Alcoholism funded the development of accreditation standards for alcoholism programs by the Joint Commission on Accreditation of Hospitals, it took the first step towards the "still far removed" goal of quality assurance and associated fiscal responsibility in alcoholism programs across the US.

The next step was to assure the quality of the manpower in the field of alcoholism.

However, in Mr Gunnersen's view, certification of personnel has fallen victim to excessive factionalism and self interest. "The questions of who will implement it and how it will be implemented have paralyzed national progress in this area, leaving certification to be implemented haphazardly by a few isolated 'professional' groups and a few state organizations . . . The question of certification for alcoholism services has been left to chance."

Further, he said, the numbers and types of individuals providing alcoholism service is increasing in geometric proportions. "Many have little or no professional or experiential training in alcoholism service delivery. Many pick up techniques and apply them with no knowledge of their theoretical or doctrinal basis, or their association with other therapeutic measures. The ethics of service delivery plummet . . . and we stand still paralyzed by indecision, arguments over turf, and an unwillingness to generate the energy required to cooperate."

All quality assurance regulations require peer review of health care services, but Mr Gunnersen said not until the alcoholism service has manpower identified by certification, and qualified by experience, practice and training, and not until it is able to define specifically what the role and function of its manpower is and what the role and function of other manpower is in providing services to alcoholic people, will it be able to "demand and substantiate equal acceptance of its peerage" with other health care providers.

"If we believe there is such a thing as the 'field of alcoholism' with an identifiable and unique body of knowledge, practices, and manpower, we must rapidly develop quality assurance mechanisms that begin with responsible internal regulation of the quality of manpower and establish a professional peerage that can assume control of service quality through credible peer review mechanisms and move towards responsible definition of the substance of quality service.

"This is not to say that we disagree with the desire to move alcoholism service delivery into the mainstream of medicine. But it is to say that the people now providing the service should continue to provide it as equal partners with unique skills and a unique body of knowledge — not as 'allied' care providers subordinate to organized medicine."

Mr Gunnersen is director of the Alcoholism Division, Accreditation Council for Psychiatric Facilities, Joint Commission on Accreditation of Hospitals, Chicago, Ill.

Rx drug abuse overshadowed by focus on alcohol

QUEBEC CITY — Twenty per cent of the chemical abusers referred to the addiction service of Royal Ottawa Hospital over three years had a prescription abuse problem.

For 4%, the abuse was limited to prescribed medications, 15% mixed abuse of alcohol and prescriptions, and 2% mixed abuse of prescriptions and street drugs.

The study was reported by Nady el Guebaly, previously head of the addiction service, and now head of psychiatry at St. Boniface General Hospital, Winnipeg. Subjects were divided into six groups depending on their "pure" abuse of one substance, or the various mixtures of abuse.

Pure prescription abusers were the only group in which women predominated.

Dr el Guebaly noted that male prescription abusers and street drug users showed "a remarkable lack of motor vehicle offences". Alcoholics were the ones charged with traffic offences, usually for impaired driving.

"We have reason to believe that the other drug abuser groups often did drive in a similar state but remained undetected. The over-whelming concern for alcohol in our present road legislation, leading to the neglect of other types of drugs, ought to be reconsidered."

Dr el Guebaly concluded that the bulk of prescription abusers is made up of alcoholics and other chemical abusers "searching for prescriptions to meet their insatiable need for chemical answers. This finding could have an impact on our focus for prevention. By emphasizing responsible prescribing to the alcoholic and street drug abusing population, we could limit a sizeable portion of prescription abusers."

He felt that preventive efforts should focus on the female population, alcoholics, and other chemically dependent groups.

"Rational prescribing defined as the right drug for the right patient at the right time in the right amounts and with due consideration for relative costs, is to be encouraged if the physician is to retain his credibility."

Alcohol-induced relaxation is risky

WINNIPEG — An alcohol-induced state of relaxation may increase rather than lessen the risk of serious injury from an auto-accident.

A University of Manitoba research group has turned up evidence that high blood-alcohol levels may increase the severity of injuries.

The group, known as the multi-disciplinary accident investigation group, studied 21 accidents over a one-year period and found three cases where young adults who had been drinking heavily died within minutes of an accident. Autopsy findings suggested their bodies should have resisted the injuries at least until they reached hospital.

"The reason (they failed to do so) might be due to the detrimental effects of alcohol on the function of both the injured and non-injured vital systems, including the heart.

"This observation is contrary to the popular myth that the probability of survival is enhanced by an alcohol-induced state of relaxation."

Industry and the alcoholic employee

In major Canadian firm

Rehab success rate for alcoholics up by 45%

LONDON, ONT. — Ontario Hydro's success rate in rehabilitation of its alcoholics has climbed from 15% to 60% since 1968.

Good treatment facilities for employed alcoholics, with speedy admissions and referral by industrial physicians, was the most important feature of the improvement, Thomas R. Hamilton told the annual Quebec-Ontario Occupational Health Conference. Dr Hamilton is assistant director, health and safety division, of Ontario Hydro.

Other factors were the improved way in which supervisors play a part in case-finding and subsequent control, and the ready availability of in-patient psycho-social group therapy programs with organized follow-up.

Betty Lou Lee reports from the Quebec-Ontario Occupational Health Conference, London, Ont. Next month, The Journal reports from the Association of Labor Management Administrators and Consultants on Alcoholism annual meeting in San Diego.

Ontario Hydro has 25,000 employees scattered throughout the province, and has the same program for all locations and employees, although greater accessibility to facilities in Toronto has concentrated much of the in-patient treatment there.

Since 1969, the alcoholism control program has dealt with 266 problem drinkers — 10 of them women — of whom 163 are still employed.

Seventeen, all men, have died either during or after leaving employment. Six of them died of alcohol-related disease like cirrhosis or cardiomyopathy, and four died violently by sucide, auto accidents, and homicide. Three more, heavy smokers, died of lung cancer and emphysema. All the men who died were between 29 and 63 years of age.

Of the 103 no longer employed, 43 retired, which Dr Hamilton said reflects the pattern of the typical alcohol problem in industry — a long-service employee who is 40 to 50 when recognized as a problem drinker. Nine retirements were forced and one woman retired early to avoid treatment.

Photo AWARE Saskatchewan department of health

Sixteen employees resigned, three of them to avoid treatment, and several to avoid discharge. Thirty-three were discharged for cause.

Dr Hamilton said the average age of the alcoholic employee is dropping, partly because the average age of employees is dropping, but also because "the recent pattern is of much younger men presenting as problems at age 29, 26, 23 and 21. These young, short-service employees have not the same attachment to their job as the older, longer-service employees, making constructive coercion less effective."

If any common pattern could be discerned among the problem drinkers, it was of "a loner type, anxious, able to feel better and to improve relationships with others by drinking alcohol."

Among the 266, 13 were diagnosed as having psychoses, 19 chronic anxiety, and 14, depression. Major physical illnesses were chronic bronchitis, 24; diabetes, 17; and atherioscleroticheart disease, 14, although it was not possible to evaluate for peptic ulcer, gastritis, or hypertension. Alcohol-related diseases were found in 57, including hepatic cirrhosis, 34; peripheral neuritis, 15; DTs, 5; and isolated alcoholic seizures, 2.

Industry has strong hold on alcoholics—money

LONDON, ONT. — Industry has a hold over the alcoholic that agencies, police, and the clergy don't, and it should use it, says the medical director of Dominion Foundries and Steel Ltd (Dofasco), Robert Martin of Hamilton.

That hold is the alcoholic's supply of money, and the constructive coercion that can be used to give him two firm options — rehabilitation or loss of his job.

Dofasco has had an alcohol rehabilitation project for 12 years for its 10,000 non-unionized employees, and this year for the first time, the number of drunks who have referred themselves to it is greater than from any other single source of referral, Dr Martin told the Quebec-Ontario Occupational Health Conference.

"We're proud of this, because it indicates employees realize they'll be helped, not fired, if they admit their problem to us. That has got around the plant by word of mouth from men who've been through the program."

Of 303 patients who had been through the program to the end of July, 60% are judged to have good results: abstinence with perhaps one or two relapses a year, and good cooperation in the program. Another 21% have had fair results, and 19% poor.

The company has a written policy that alcoholic employees are eligible for sickness benefits. The program consists of three or four weeks at the alcoholism unit at Chedoke Hospitals, plus another year of follow-up in which the family is also involved. If Antabuse or Temposil are prescribed, it is mandatory the worker get it at the company first aid station before or after shift.

A basic foundation of the program is educating foremen to report (but not to diagnose) behavioral problems, Dr Martin said. Careful record keeping on absenteeism, sick leave, safety performance, and work performance, is also essential to the Dofasco program. These records are all available when the worker is called in for an interview.

"It's useless to confront him until you have the facts, not just rumor, and those take time to gather. If you don't have the facts, he'll bluff you out of your trousers. But when he is confronted, without indecision on your part, he often dissolves like a pack of cards and is glad it's finally in the open."

Dr Martin stressed that only on-the-job performance can be used to coerce someone into treatment. "He can be stoned nightly, but if he's not a hazard, and he's working properly, you can't touch him. But I let him know I know about it and watch him."

Of the 303 people who have taken part in the program, 17 eventually were fired for alcoholism, "which is not too bad in 12 years".

Other than self-referrals, foremen accounted for the next largest group reported to the medical department, 58. Security guards who spotted drunkenness at the gates, and family doctors each sent 19. Parents reported two workers, and a son reported his father. In one case, it was an Alcoholics Anonymous member who notified the department. "This is usually a no-no for AA members, but this one was working beneath an alcoholic crane operator."

For drug abusing employees

Large companies need counsellors

LONDON, ONT. — If a company has more than 3,000 employees, it may be economical to hire a full-time professional for case-finding, referral, and follow-up of employees who are abusing chemicals, says the coordinator for Corporate Drug and Alcohol Abuse at the Ford Motor Co. in Dearborn, Mich.

Smaller companies could share a social worker or other professional, J. L. Francek told the annual Quebec-Ontario Occupational Health Conference.

In his studies, he has found alcoholic employees have six times the absentee rate, four times the sickness and accident claims, and many more grievance and disciplinary procedures.

They are 4% to 11% of the work force, and they cost their employers 25% of their average income. But 65% to 70% of them may be rehabilitated with a program that is consistent, confidential, and sympathetic.

"I'm not saying he should be babied. He has accountability for keeping his job. But he has to be given time," he said. In some cases finally losing his job can be "the best thing that can happen therapeutically".

Physiclans in business and industry have a number of responsibilities in this area, Mr Francek said. They must find out what community resources are available. "You know this for coronary cases, why not for alcoholics?". If services don't exist, they should go into hospitals to point out the need, and act as catalysts in the community to develop programs.

They should survey the system of denial that exists in the company, including its medical department. "If a man has a lump on his arm, his supervisor knows it should be looked at, but he doesn't take the same attitude to a change in work, behavior or mood. Why do supervisors hide the problem until the last stage?"

He cited the example of a worker who kept urging everyone to listen to the symphonic quality of the clanging presses in his work area. When finally referred to the medical department, he was found to be psychotic, homicidal, and suicidal.

The company doctor must also help unions and management to work out their roles in any alcoholism program, and ensure that company benefit programs reflect alcoholism as a health problem. Recovery teams representing the medical department, union, and management can be used to motivate employees to accept help.

Mr Francek said one heroin addict in 1,000 dies if he tries to withdraw from chronic addiction without medical attention, but one in 20 chronic alcoholics do.

Florida centre regroups

ORLANDO, Fla. — The Mid-Florida Center for Alcoholism has finally been able to regroup its headquarters and inpatient services under one roof here, after two years of making do with a split operation.

A couple of years ago the alcoholism centre went thrangh the traumatic experience of losing a new headquarters building it was all set to move into (The Journal, May 1, 1975). With only 30 days in which to relocate all the facilities of what has been described as one of the best alcoholism programs in the country, the MFCA had to settle for housing its administrative offices, outpatient services, and information and referral facilities in an old converted downtown residence, while moving its inpatient service and certain other programs into one wing of a motel 10 miles away.

This wasn't a satisfactory setup from the viewpoint of efficieney, but the centre seems to have maintained its standard of achievement despite the handicap. According to Betty Jo McLeod, executive director, a recent follow-up af a sample group of patients found 74.2% still abstaining six months after in patient treatment, with a 31.6% increase in employment

Drunk drivers should be scorned not pitied

OTTAWA — Drivers convicted of impaired driving should be the butt of public scorn rather than the recipients of public sympathy, according to Philip Farmer, executive director of the Canada Safety Council.

Speaking at a council conference here recently, Mr Farmer stressed that solid public support is needed for Canada's drinking and driving laws and their enforcement by police forces.

Until this is achieved, there will be slow progress in bringing impaired driving under adequate control. At present, the drinking and driving problem is out of control despite the Criminal Code amendments concerning mandatory breathalyzer tests.

Mr Farmer expressed optimism about the more recent additions to the Criminal Code covering roadside screening tests.

"This new law gives Canada's law enforcement agencies a powerful tool," he said.

"The use of roadside screening tests with selective enforcement and concentration at high risk places and times, can result in a reduction in impaired driving."

Under the most recent amendments, a police officer may request a roadside screening test of a driver suspected of being impaired. Most likely, the roadside screening tests would be given to patrons of bars, road houses, and taverns.

People signalled as being impaired by the portable breath testing units would be given a more formal breathalyzer test at the local police station for use in any criminal charges.

One problem with roadside screening tests is that so far, only two provinces, Alberta and Ontario, have indicated they will implement them. And shortage of equipment and trained personnel will delay implementation for several months.

Drug program evaluations

Miami tries to eliminate the 'inevitable bias'

By Tom W. Hill

MIAMI — Most follow-up studies carried out to evaluate the effectiveness of drug treatment programs have a built-in bias that makes their validity questionable, say investigators in the Division of Addiction Sciences at the University of Miami School of Medicine.

James Inciardi

The bias derives mainly from the fact that it's seldom possible to locate more than 50% of the population to be followed. And often, the people doing the study fail to define the characteristics of the unlocated group.

But the Miami investigators believe this bias isn't necessarily inevitable. Based on what they've learned in studying the problem, they've been able to develop strategies to decrease the bias.

A research team — Brian R. Russe, Duane C. McBride, Dr Clyde B. McCoy and James A. Inciardi — sought to find out why some patients couldn't be located at follow-up. They also compared the social and behavioral characteristics of those who could be located with the characteristics of those who could not.

They started their study in the emergency room of Miami's 1,300-bed Jackson Memorial Hospital. For a six-month period they stationed a team of counsellor/interventionists in the emergency room from noon to midnight, four days a week, to offer counselling, intervention and referral services to patients who came in as a result of adverse reactions to drugs.

After an initial interview, the team offered each patient referral services to various agencies. This served to test the theory that referral activity which takes place in a hospital emergency room will effectively alter the drug taking behavior and life style of many patients seen there for treatment of drug related problems.

Upon completion of the intervention phase of the project, the team members began a follow-up study. Of 184 patients, they were able to locate and interview only about 45%. A total of 101 weren't available for the follow-up interview.

More than half (actually 60.4%) of the unlocated patients had moved and left no address. Another 13% weren't located although their addresses appeared to be current and correct; they weren't found at home despite at least five attempts to contact them. Two patients had died. Five had given false addresses when seen originally. Twelve patients refused to be interviewed and six others were deemed inappropriate for interview for various reasons.

Duane McBride

Analyzing the data by race and sex to determine which categories of patients were most readily available for follow-up, Mr Russe and his associates found that white males were the most available. Only 45% of white males were not reinterviewed, compared to 65% of white females, 60% of Spanish males, 61% of Spanish females and 53.3% of black males. Black females were almost as accessible as white males (only 47.8% not being reinterviewed).

Patients who had come to the emergency room because of reactions to illicit substances tended to be less available for follow-up than those who had used prescription type medications. Some 68% of the former, compared to 53% of the latter, were not reinterviewed.

Patient availability for follow-up correlated to some extent with the type of agency to which referral was made. Generally speaking, patients using illicit substances were sent to traditional drug programs, while prescription medication users were invariably sent to psychiatric out-patient counselling agencies.

The group most accessible for follow-up turned out to be patients referred to traditional drug treatment agencies. Seventy percent of those referred to comprehensive drug programs were available for follow-up.

The least accessible were individuals referred to the hospital's crisis intervention outpatient clinic for short term psychiatric counselling; only 45.1% of these were located for reinterview. Mr Russe, who is a research associate in the Division of Addiction Sciences, believes that the radical changes in life style required by therapeutic communities (in contrast to the less stringent requirements of psychiatric counselling) may at least partly explain this difference in accessibility.

One implication of the study, the researchers point out, is that follow-up studies tend to be biased toward findings from institutionalized populations, since this group is the one most readily located. The very fact of institutionalization implies that the individual is still using drugs. He is probably not truly representative of the original patient population, many of whom have avoided institutionalization and are more likely to have ceased using drugs.

This research also suggests strategies for obtaining a higher proportion of respondents in follow-up studies:

- Since the major reason people couldn't be located was because they had moved, researchers should anticipate this and be prepared to spend time and effort to locate former patients through friends, neighbors, treatment programs and the criminal justice system.
- Efforts should be made to enlist the cooperation of the individual during the initial interview, to persuade him to "keep in touch."
- Intervention agents, because the role they play may be the key to success or failure, should be thoroughly experienced in counselling and interviewing and be involved in sensitivity, awareness and communications groups.
- Field investigators should obtain grass roots cooperation in advance by contacting local organizations and agencies and explaining the importance of follow-up and how community support can help.

Brian Russe

Alcohol care snubs families

NEW ORLEANS — The family is still being neglected in alcoholism treatment.

The majority of treatment programs continue to focus on the alcoholic as the primary patient. Yet generally accepted estimates indicate the nine to 12 million persons suffering from alcoholism in the United States each directly affect the lives of four to five "significant others".

This suggests that in addition to the "alcoholics" there are 40-50 million people (in the US) who are suffering the effects of alcoholism but who by and large are neglected.

"When families are included in treatment, it is more of an adjunct to the primary patient than reception of direct services for their own recovery," said Orville McElfresh from the Alcoholism Treatment Center at Lutheran General Hospital in Park Ridge, Ill.

He urged those attending the meeting of the Alcohol and Drug Problems of North America here to look at the potential of active family treatment. "In the long run, when a family system makes significant changes there will be a major impact on the alcoholic person and the family's future mental health."

The family deserves the same sensitive and therapeutic response as the primary patient, said Mr McElfresh. And he suggested a multi-option approach for the patient and family is necessary to begin to meet the needs of persons suffering from alcoholism.

"When developing a treatment plan for the family, it is important this plan parallel the plan for the primary patient. If the initial focus for the patient and family is too intense on relationship issues, basic alcohol information can be missed and the focus will revert to intrapsychic issues."

Mr McElfresh also emphasized the energy necessary for early recovery on the part of patient and family. "Intense marital and family issues can be responded to more effectively after three to six months of sobriety has been established."

Assessment of individual family members is crucial to a successful treatment program. Family members may be suffering from more than alcoholism and may need referral for further medical and/or psychological examination and treatment before they are available to participate in alcoholism treatment.

Similarly, Mr McElfresh pointed out family needs will change as the crisis stage passes and treatment progresses. "The counselling staff must sort out the issues and together with the family and patient develop short and long term treatment goals."

At the crisis stage the family members are frequently unable to respond to the requests of the treatment facility and often do not receive the necessary support to begin to understand their roles in the illness.

"All too often the first thing the family hears is that it is 'as sick as the patient'. This tends to raise defenses and activate guilt feeling," said McElfresh.

"The family is indeed sick and the system of personal relationships has been distorted. How the family is part of the illness needs to be more carefully communicated."

War on 'social' drinking under way

By Bryne Carruthers

OTTAWA — Four years after the federal health department first announced it was going after alcohol as one of the country's leading health hazards, federal health minister Marc Lalonde has announced what he calls the first step in a comprehensive alcohol program.

It's a $650,000 nation-wide advertising campaign aimed at convincing "the social drinker" to take it easy with alcohol.

The $650,000 advertising program represents a sizeable portion of the health department's $9 million information budget. Despite this, Mr Lalonde doesn't really expect the program will produce measureable changes in the drinking activities of Canadians.

With the fancy title "Dialogue on Drinking," the advertising campaign started Oct 7 and will continue to March 1977 using major daily newspapers, magazines, and radio in large urban areas.

"This is not a fight against drinking," the minister said, but "rather a fight against irresponsible drinking."

All provinces but Ontario and Quebec have agreed to participate in the program by adding their names to the advertisements and by providing educational material on request.

In Ontario, the Addiction Research Foundation has decided to participate, according to the minister.

But the federal government is footing the total bill.

Realistically, the federal government can do little to assist in what amounts to changing a lifestyle, other than perhaps trying over the long term to increase people's awareness about the problems associated with excess drinking, the minister suggested.

He said the alcohol industry, along with the advertising community, and the mass media, were asked to respond by the end of last month to a list of federal suggestions for additional regulatory actions aimed at curbing consumption of alcohol.

Included in these is a federal proposal to require labels on alcohol bottles, similar to those on cigarette packages, warning about the health hazards of drinking.

Another proposal being considered is Mr Lalonde's pet concern about the so-called good life emphasis in alcohol advertising, where young, happy, and good-looking people are shown to be the ones drinking Brand X.

While the alcohol industry argues their advertising is aimed at switching drinkers from one brand to another, Mr Lalonde believes this type of advertising convinces young people to start drinking as well.

He expressed regret that some provinces lowered the minimum drinking age to 18 years as this resulted in a sharp increase in adolescent drinkers.

"It has made an impact on the schools in particular, introducing drinking into high schools where you now have 15- and 16-year-olds drinking," he said.

Looking back, the minister suggested perhaps the minimum age limits for drinking were lowered by some provinces "on philosophical grounds," with little hard data to back up the move.

Control of print advertising is within provincial jurisdiction. And Mr Lalonde would like to see a standardization of alcohol advertisements in newspapers and magazines from province to province.

At present, some provinces such as British Columbia, Saskatchewan, and New Brunswick ban certain alcohol advertising, while neighboring provinces are quite liberal about their approach to advertising.

With respect to electronic media advertising, which the federal government already regulates through the Canadian Radio and Television and Telecommunications Commission, Mr Lalonde indicated he would like to see tougher regulations along with standardization from province to province.

He specifically pointed to the fact Manitoba prohibits alcohol advertising on television before 10 pm.

As part of his package of proposals to industry, Mr Lalonde has suggested a nation-wide ban on alcohol advertising on television before 9 pm.

Before any of the tougher regulations on alcohol advertising labelling would be recommended to the federal government, Mr Lalonde would consult once more with the provinces as promised.

On the general issue of drinking, Mr Lalonde said at one point that he does not think young people need alcohol to enjoy life.

He added, at another time, that it would not be realistic to think of eliminating alcohol use.

The over-riding fear in government is that another Prohibition would just lead to more bootlegging.

In somewhat evasive language, a background paper on the program notes that Dialogue on Drinking does not offer specific solutions to this complex social problem.

"This does not mean that governments are not seeking solutions but rather that the nature of the problem requires everyone's involvement.

"Governments can do their part only when supported by the public."

Within the federal government at least, the health experts have been seeking for solutions to the problem for more than four years, so far in vain.

The alcohol industry has known for some time that increased government regulation was in the offing. Some segments of the industry have been running ads urging moderation and promoting public education about the hazards of drinking; others have been running "None for the road" ads warning drivers against driving their cars.

Nonetheless, the arguments expected from the distilleries, breweries and wineries — who spend $50 million annually in Canada on promotion — emphasize economic rather than health aspects. These arguments point out that advertising agencies need the money generated from the promotion of alcohol; that some consumer magazines might not be able to stay in business without the revenue from such advertising; that the advertising of alcoholic beverages is aimed at winning larger shares of an existing market rather than expanding overall consumption; and that more than 35% of sports broadcasting is sponsored by breweries.

In mid-September The Magazine Association of Canada presented a brief to Mr Lalonde showing that foreign magazines carrying alcohol ads had a combined per-issue readership in Canada of 17 million and were beyond the government's control.

'Your Personality Profile'

Health and Welfare quizzes Canadian families

OTTAWA — Self-scoring questionnaires which were developed to show Canadians how healthy or unhealthy they are have been distributed across the country with last month's Family Allowance cheques.

Developed by Health and Welfare Canada as part of the public education campaign "Operation Lifestyle", the quiz "Your Lifestyle Profile" was an attempt to allow the 3.6 million Canadians who received it last month to determine the quality of their lifestyle and see where improvements could be made.

"Dialogue on Drinking" (see story above) is another aspect of the Operation Lifestyle program announced several months ago by Health and Welfare minister Marc Lalonde.

A follow-up leaflet "Ways to Improve Your Lifestyle Profile" will be sent with November Family Allowance cheques.

Copies of both the questionnaire and follow-up material are available from the Information Directorate, Department of National Health and Welfare, Ottawa Canada, K1A 0K9.

Instructions

Indicate by circling or checking only the responses that apply to you. See "Your Score" at end of the quiz to determine the quality of your lifestyle.

Exercise

Amount of physical effort expended during the workday?
(a) heavy physical (b) desk work
Participation in physical activities — skiing, golf, gardening, etc?
(a) daily (b) weekly (c) seldom
Average miles walked or jogged per day?
(a) More than 1 (b) less than 1 (c) none
Flights of stairs climbed per day?
(a) more than 10 (b) less than 10

Nutrition

Are you overweight?
(a) no (b) 5 to 19 lbs (c) more than 20 lbs
Do you eat foods from each of the following groups — (1) meat, fish, poultry, dried legumes, eggs or nuts (2) milk or milk products (3) breads or cereals (4) fruits (5) vegetables?
(a) everyday (b) 3 times weekly

Alcohol

Average number of bottles of beer (12 oz) per week?
(a) 0 7 (b) 8 15 (c) 16 or more
Average number hard liquor (1 oz) drinks per week?
(a) 0 to 7 (b) 8 to 15 (c) 16 or more
Average number of glasses (5 oz) of wine or cider per week?
(a) 0 to 7 (b) 8 to 15 (c) 16 or more
Total number of drinks per week — beer, liquor, wine?
(a) 0 to 7 (b) 8 to 15 (c) 16 or more

Drugs

Do you take drugs illegally?
(a) no (b) yes
Do you consume alcoholic beverages together with certain drugs — tranquillizers, barbiturates, antihistamines or illegal drugs?
(a) no (b) yes
Do you use pain-killers improperly or excessively?
(a) no (b) yes

Tobacco

Cigarettes smoked per day?
(a) none (b) less than 10 (c) more than 10
Cigars smoked per day?
(a) none (b) less than 5 (c) more than 5
Pipe tobacco pouches per week?
(a) none (b) less than 2 (c) more than 2

Personal health

Do you experience periods of depression?
(a) seldom (b) occasionally (c) frequently
Does anxiety interfere with your daily activities?
(a) no (b) occasionally (c) frequently
Do you get enough satisfying sleep?
(a) yes (b) no
Are you aware of the causes and dangers of VD?
(a) yes (b) no
Breast self-examination? (If not applicable, do not score).
(a) monthly (b) occasionally

Road and water safety

Mileage per year as driver or passenger?
(a) less than 10,000 (b) more than 10,000
Do you often exceed the speed limit?
(a) no (b) by more than 10 mph (c) by more than 20 mph
Do you wear a seatbelt?
(a) always (b) occasionally (c) never
Do you drive a motorcycle, snowmobile or moped?
(a) no (b) yes
If yes to the above, do you always wear a regulation safety helmet?
(a) yes (b) no
Do you ever drive under the influence of alcohol?
(a) never (b) occasionally
Do you ever drive when your ability may be affected by drugs?
(a) never (b) occasionally
Are you aware of water safety rules?
(a) yes (b) no
If you participate in water sports or boating, do you wear a life jacket? (If not applicable, do not score).
(a) yes (b) no

General

Average time watching TV per day (in hours) *(a) 0 to 1 (b) 1 to 4 (c) more than 4.*
Are you familiar with first-aid procedures?
(a) yes (b) no
Do you ever smoke in bed?
(a) no (b) occasionally (c) yes
Do you always make use of clothing and equipment provided for your safety at work? (If not applicable, do not score).
(a) yes (b) occasionally (c) no

To score

1 point for each (a) 3 points for each (b) and 5 points for each (c)

Excellent 34-45

Congratulations! "Excellent" indicates that you have a commendable lifestyle based on sensible habits and a lively awareness of personal health. Keep up the good work and maintain this rating.

Good 46-55

You have a sound grasp of basic health principles. Only one to 10 points separates you from the elite. With a minimum of change you can develop an excellent lifestyle pattern. Make the effort to move up to "Excellent" and stay there.

Risky 56-65

You are taking unnecessary risks with your health. Several of your lifestyle habits are based on unwise personal choices which should be changed if potential health problems are to be avoided. A few common-sense decisions can mean a "Good" rating, but the challenge is to move your lifestyle up to "Excellent".

Hazardous 66 and more

A "Hazardous" rating indicates a high risk lifestyle. Either you have little personal awareness of good health habits, or you are choosing to ignore them. This is a danger zone — but even hazardous lifestyles can be modified and potential health problems overcome. All it takes is a little conscientious effort to improve basic living patterns. Go over your test carefully and start making those improvements right now.

Burglar proof

A cigarette case with a catch — a built-in time lock that keeps the case firmly locked for up to two hours — has been introduced in Britain. Manufacturers claim the case will help a smoker cut down his habit by controlling the number of cigarettes he smokes in a pre-determined time.

Wild rumors

Hong Kong drug pushers, desperate to scare customers away from treatment programs, are spreading rumors methadone can make a person infertile, impotent, and cause skin to turn green. And if that's not enough to scare addicts away from methadone maintenance programs the pushers claim death by the drug may result.

No smoking here

Quantas, Australia's national airline, has enlarged non-smoking sections in its aircraft following a six-month survey of passenger preferences. No-smoking seats in Boeing 707s and 747s average about 50%. The percentage is slightly lower (about 40%) in first class sections.

Fisherman's shoes

A Thai seaman was sentenced to seven years in jail after being charged with possession of morphine valued at $23,000.. A baggage inspector at Kaitak Airport in Hong Kong became suspicious when he noticed a passenger's extra long trousers and high platform shoes. After the inspector broke open the heels of the suspect's footwear he found morphine in the shoes of the fisherman.

Self serve deaths

The British Pharmaceutical Society is trying to step up its drive to have self-serve sales of analgesices and other medicines banned in supermarkets arguing too many people are dying from accidental poisoning. Manufacturers claim such a move will only inflate drug prices because of decreased sales. About 60% of £20 million worth of analgesics sold each year are bought at general retail shops, many of them self-serve.

Chew developed for smokers

LONDON — A nicotine flavored chewing gum designed as a substitute for cigarettes is being developed in Britain, and should be available to people wishing to give up smoking within a year.

The chewing gum, tasting of nicotine with an overriding and more palatable flavor, was originally conceived five years ago, but the early product had only a relatively small quantity of nicotine. The latest version contains between 2 and 4 milligrams of nicotine — while individual cigarettes contain between 0.5 and 2 mg.

Nicotine is the addictive element in tobacco. The dangers of smoking are associated with the tar which collects in the lungs.

The research project is being carried out at the Addiction Research Unit of the Institute of Psychiatry at Maudsley Hospital, London. A medical team led by Michael Russel is experimenting with volunteer patients who want to stop smoking.

Dr Russel says the gum is so far the best of many projected aids for nicotine addicts. Among the 43 people tested, 70% stopped smoking during the trial period; and 26% of those who completed the tests were still not smoking after a year.

Subject to approval by the department of health, the nicotine gum is expected to become available to the public within a year. In all probabillty, the product will be restricted to prescription inltially.

Commercial aspects of production, distribution, and marketing have not as yet been considered; and the research team decline to guess how much the gum would cost.

Contact: Addiction Research Unit, Institute of Psychiatry, Maudsley Hospital, Denmark Hill, London, S.E. 5, England.

Bavaria sets up smokeless zones

Non-smokers breathing freer

By John Dornberg

MUNICH — The Bavarian state government has adopted measures to protect non-smokers from smokers in public service.

A decree issued by the Bavarian State Chancellory, effective in September, restricts smoking in government offices, vehicles, and the canteens and cafeterias of government buildings.

Specifically, the edict prescribes that "wherever possible," smoking and non-smoking civil servants should be assigned working spaces in separate offices. Where this is not possible, smoking in offices should be permitted only "if all the employees in the room agree to it".

The policy on smoking at conferences and meetings should be determined before sessions open and smoking should be permitted only when all participants agree. Exceptions may be made in very large auditoriums and under certain circumstances the agenda should forsee cigarette breaks.

No smoking will be permitted by passengers in government vehicles unless all of them riding in the vehicle agree to a smoking policy. Drivers of government vehicles must not smoke at the wheel, according to the decree.

Canteens and cafeterias in public buildings should be divided into smoking and non-smoking rooms or sections, and where this is not possible for space reasons, smoking and non-smoking tables should bc designated. Where separate facilitics for smokers and non-smokers cannot be set up, according to the edict, smoking must be prohibited during the main lunch period from 11:30 am to 1:30 pm.

The decree bans smoking in all classrooms of Bavarian schools and universities, and places restrictions on smoking on government offices frequently visited by the public.

Of the 10 ministerial undersecretaries who signed the decree, seven are non-smokers. Of the three who do, two smoke cigarettes and one a pipe.

They supply 600 tons a year

Burma and Laos may cut back opium production

GENEVA — Burma and Laos have given secret undertakings to the United Nations agencies concerned with the illegal narcotics trade that they would substantially reduce their supplies.

These two countries produce more than 600 tons of opium a year and, together with Thailand, make up the notorious Golden Triangle region, the principal source of the illicit trade in Western Europe and North America.

The confidential nature of their undertaking to the international community may well indicate a gesture outside the realm of public relations. There is, in fact, a great deal both countries can do to cut down the volume of their illicit supplies.

Both Burma and Laos avoided the recent Euro-Asian discussions on the illegal narcotics trade held in Chieng Mai, northern Thailand, which has become the main Westward trade route used by traffickers since the Communist takeover in Vietnam and Laos.

But the meeting, brought together by Interpol and the Colombo Plan aid organization in search of new cooperative arrangements for reducing drug trafficking, received firm indications from both countries that they would join the UN-sponsored crop substitution program for poppy growing regions.

Under the scheme, growers are to be encouraged — or coerced — to cultivate alternative crops producing a guaranteed income. The details are to be worked out with the UN's International Narcotics Board and the UN Fund for Drug Abuse Control here. They can supply both specialist advice and funds for essential investment.

Thailand is already working closely with the UN agencies. Its administration is anxious to gain international recognition for its efforts to reduce the Westward flow of drugs from the Triangle. Both Burma and Laos have pressing domestic reasons to cut down opium production but, like Thailand, neither is able to eliminate the industry entirely.

Burma has paid lip service to the crop substitution program for some time; but hitherto it has displayed neither the will nor the ability to mount more than an occasional token raid on the highly organized refineries where the hill gangs convert opium into heroin along the border with Thailand.

The revenues raised by the Burmese opium trade are used largely to finance the intensifying guerilla warfare against the central government. A crop substitution program, even if only partly implemented, would financially weaken the opposition armies. The administration's undertaking to reduce the poppy fields could therefore be given credence in the context of its drive to extend its territorial authority at home.

Laos legalized the cultivation of opium poppies last year after the Communist Pathet Lao leadership assumed power. The move was evidently intended to pacify the hill tribes hostile to the Communists. Poppy growing, a traditional local industry, had been banned by the previous administration.

The farmers responded to the end of prohibition by raising a crop yielding some 30 tons of opium; and they are planning to increase cultivation. But they are likely to be disappointed as the new administration intends to introduce measures for crop substitution, with aid and advice from the UN agencies, now that the dissident tribes have been brought largely under control.

Any practical measure to reduce opium production in the Triangle area could significantly alter the availability of supplies in the rich illicit markets of the European Economic Community as well as in Canada and the United States.

Customs and police seizures of top grade heroin totalled 200 kilograms during the first half of this year in Western Europe alone.

UK Labour party digs in its heels on smoking

By Harvey McConnell

LONDON — A wide range of controls on cigarette advertising, as well as statutory powers to control tobacco additives and suhstitutes — despite American company opposition — has been devised by the Labour Government here.

But while tobacco manufacturers have made it plain to David Owen, Minister of State for Health and Social Security, that they will go along with efforts to make cigarette smoking "safe", they would not support measures even over the long term, to abolish smoking altogether.

Announcing the changes to parliament, Dr. Owen said: "Some believe even to talk ahout safer smoking is to compromise one's stand against all smoking. I do not believe that this is realistic."

Dr Owen said the tobacco companies had agreed to these proposals.

- Tar content and group (high, medium or low) will appear on cigarette packs in the future;
- Advertising of cigarettes in movie houses will he restricted to films rated for adults only;
- Cigarillos will no longer be advertised on the commercial television network, on which cigarette advertising has been banned for a number of years;
- Negotiations are to start soon on limiting tobacco company sponsorship of sporting events and sports bodies. In Britain this extends from automohile racing to golf, tennis and cricket. The John Player cricket league, played on Sundays, has been a financial boon to hard-pressed county cricket clubs.

Dr Owen said a main aim is to achieve a steady reduction over the next few years in the tar yield and other smoke constituents, such as carhon monoxide and nicotine, judged on independent medical evidence to be excessive.

He accepts progress will be slow. One way to start is to stop gift coupon schemes linked with high tar cigarettes. Eventually all gift coupon schemes will he ended.

Opposition to part of the proposals has come from American-owned companies who oppose the plan to put additives and substitutes under control of the Medicines Act.

Dr Owen said: "The Government considers on the basis of agreement by companies responsihle for the production of over 70% of the cigarettes consumed in this country, including the largest British producer, it would he unreasonahle not to go ahead.

"To do otherwise would be to allow the interests of firms outside the country to frustrate what the home industries are prepared to carry forward in the interests of the health of the people of this country."

In future all tobacco additives and substitutes will need a product licence from the Government, which will be advised hy an independent scientific committee.

The voluntary part of the proposals met with full agreement of the companies. Imperial Tobacco, which controls two-thirds of the British market said it "welcomed the new cooperative agreement with Dr Owen."

Dr Owen rejected the call by many memhers of parliament to ban all cigarette advertising. He said one bad effect would he to hinder the spread of the message — through ads — of the effect of the supposedly safe low tar cigarette.

Any attempt to price cigarettes off the market would mean the poor would suffer while the rich would continue to smoke. These social consequences, Dr Owen said, "are quite unacceptable".

Drownings by alcohol

MUNICH — One-fourth of West Germany's accidental drownings may he caused hy alcohol Intoxlcatlon.

According to the Munich-based organization Das Sichere Haus, a West German accident prevention group, of 900 fatal swimming accidents recorded in West Germany and West Berlin each year, approximately 25% have been traced to inebriation.

Soviets launch 'gigantic' anti-alcoholism plan

By Thomas Land

VIENNA — Public health and law enforcement authorities in the Soviet Union are launching a gigantic campaign against alcoholism, a growing source of crime, accidents, and industrial inefficiency.

"Drying-up" stations for the compulsory detention of drunkards are being established in many areas. Special local commissions to organize and oversee the campaign are being set up, linking various civic groups and youth organizations.

A special part-time police force is being recruited and trained to deal specifically with alcoholism. Hundreds of drunken employees are summarily fired and their cases locally publicized.

The current increase in alcohol consumption in Russia is estimated at 5% a year, compared with 3% in other major industrial countries. The nation collectively spends an equivalent of $40 billion annually on drinks, accounting for 10% of the total disposable personal income. The average Russian family, in other words, spends proportionately twice as much on drinks as the average British one.

The nationwide campaign was triggered by the Supreme Court of the Soviet Union. Concerned by the magnitute of the problem — reflected by an estimated 600,000 drunken driving offences a year, according to the authoritative *Lituraturnaya Gazeta* — the court devoted a special session late last year to alcoholism and also to drug addiction.

It resulted in a directive to lower courts instructing them to institute careful investigation into all cases of juveniles involved in drink-related offences and to hand out severe punishments to adults "found to be party to the crime".

For the court was told in a specialist report that heavy drinking, traditionally accepted and often even expected by adults in all layers of society, is spreading to younger age groups. The survey claimed that 75% of a random group of 12-year-old children studied were found to be regular tipplers, and that nine of ten 16-year-olds were regular drinkers.

The statistical testimony bore out the experience of the courts which had punished tens of thousands of juveniles for drink-related offences. But juvenile drinking is only one dramatic aspect of a problem affecting the whole of society where the average family spends 230 rubles on vodka a year — and only two rubles on books.

More than 70% of all assaults are being committed by people in a state of intoxication, according to official estimates; and 65% of murders are blamed on drink.

The authorities acknowledge that the overall low industrial productivity of the country is at least related to its high and increasing alcohol consumption.

Nearly a third of industrial accidents result from drinking: a spot check in a Moscow factory recently, mounted in connection with the current campaign, found 281 out of a total staff of 410 workers incapable of carrying out their duties safely and efficiently because of either drunkenness or hangovers.

Denouncing heavy drinking in agricultural areas, *Pravda* says: "Instead of perhaps 60 or 80 guests at a wedding, as was the case a decade ago, there are now several hundred. The celebrations last for several days; vodka, wine, and home-made brandy flows; and people compete as to who can give the bigger reception or drink the more or make the most drunken noise . . ."

What is the cause of such universal heavy drinking?

Western commentators point to the many frustrations inherent in Soviet life and to the lack of a variety of consumer goods to play with. The Soviet authorities speak of growing affluence and social irresponsibility without which a national drink problem of such intensity undoubtedly would not be possible.

However, the answer is unlikely to be that simple. At the very least, the wild drinking and even the much publicized current drive to suppress it appear to be a desperate plea for attention to underlying social ills. But they would require precisely the kind of dispassionate sociological investigation disregarding ideological implications which the Soviet system of government cannot afford to permit.

from page 9

More Letters...

AA works because of belief in 'higher power'

problem. The Bible clearly states in Galations 5:21, that drunkenness is a sin. You cannot be forgiven for a disease, but you can be forgiven for a sin. If one would read further in Galations one can find the answer to Charles Becker's question of what to give the alcoholic in return for his giving up drunkenness. I have met many alcoholics and have treated many and usually it is very hard to get any of them to stay on any kind of abstinence route unless they come into this type of relationship. A great part of the success of Alcoholics Anonymous is due to the fact they believe in a higher power greater then man.

I feel the debate of whether alcoholism is a disease or not can best be summed in the words of Peter L. Ream: "Alcoholism is a disease? If so, it is the only disease that is contracted by an act of the will. It is the only disease that requires a licence to propagate it. It is the only disease that is bottled and sold. It is the only disease that promotes crime. It is the only disease that is habit forming. It is the only disease that is spread by advertising. It is the only disease that is given for a Christmas present."

Ivan M. Jackson, MD
850 Alpha Street,
Owen Sound, Ontario

Abstinence is neglected

To the Editor:
On reading the August edition, I note with disgust that nothing has been reported in **The Journal** with regard to (Salvation Army) Commissioner Arnold Brown's recent address, emphasizing total abstinence as an alternative to alcoholism.

You covered many of the other philosophies and aspects of The Canadian Foundation on Alcohol and Drug Dependencies conference (INFORMACTION). With so many who recognize total abstinence as the only alternative to alcoholism, this speech ought to have been reported.

Austin Millar
Major, The Salvation Army
Harbour Light Corps
Toronto, Ontario

Correction

To the Editor:
On Page 7 (**The Journal**, August) in the article on Canada's drinking drivers, I believe you have made a mistake. You talked about 3,000 deaths costing $360 billion ($120,000 per fatality). If you multiply $120,000 by 3,000, the answer is $360 million.

I find it difficult to believe any country could afford $360 billion.

Thank you for your kind attention. I enjoy **The Journal** thoroughly.

J. Takamine, MD President
Alcoholism Council of Greater Los Angeles
Chairman, AMA Committee on Alcoholism

Is this your own personal copy of The Journal?

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The Journal, published by the world-renowned Addiction Research Foundation of Ontario, is the international newspaper in the field of alcoholism and drug dependence. Each month, and more than ever, people in this field — doctors, lawyers, teachers, nurses, social workers, policemen, government officials, even private citizens — are turning to The Journal to keep in touch with what's happening.

Why The Journal?

IT'S IN THE KNOW:

It is one of a kind in having an established network of respected medical journalists and columnists in Canada, the United States, Europe, and the Middle and Far East. Each month, they provide intelligent, informed coverage of all important international developments in treatment, research, education, and social and political policies.

IT'S GROWING:

As the field of addictions has broadened, so has The Journal's coverage widened. The Backgrounder has been added for readers who want to know the finer details behind some of the major news stories. The increasingly popular Back Page always highlights one particular topic or event. And, the Coming Events column is now a must for people who want to make conference plans.

IT'S HIGHLY READABLE:

If the content of The Journal has improved, so has its "look". A staid image doesn't imply accuracy or respectability any more than verbosity implies insight.
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We get letters

"The Journal sets a pattern which will become the sine qua non of good journalism in this field."
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Addiction Research and Treatment Corporation
Brooklyn, New York

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Officer in Charge, Drug Squad
Surrey Hills, Australia

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CUT THIS ONE AND MAIL

Positions Available

New Books

by RON HALL

Perception in Criminology

. . . edited by Richard L. Henshel and Robert A. Silverman

This edited work is intended to incorporate labelling material, criminogenic perception, and perception in the administration of justice in order to facilitate research efforts of criminologists who wish to deal with the subjective aspects of their field. One of the aims of the collection is to reinforce the importance of perceptual error in the production of criminality and the actual operation of criminal justice systems. Attitudes toward drug and marijuana use and police perception of drug users are briefly mentioned.

(Columbia University Press, 562 W 113th St., New York, New York, 10025, 1975. 489p.)

The Patient With Alcoholism and Other Drug Problems

. . . by Charles L. Winfield and Kenneth Williams

This book deals with the medical aspects of alcohol and other drug problems, and has been designed to provide a learning program for medical students, residents in training, and practising physicians. Pre/post tests are provided for each of the 20 parts enabling the reader to use the book as a self-study source and as a reference. Aspects covered include diagnosis, treatment, alcohol and the family, liver disease, medical complications, withdrawal, pharmacology, prevention, the susceptible physician, and others.

(Southern Illinois University, School of Medicine, PO Box 3926, Springfield, Illinois, 62708. 1976. 589p.)

Other Books

American Drugstore: A (Alcohol) to V (Valium) — Fort, Joel, and Cory. Brown and Company, Boston, 1975. Motives for drug use, medical origins, research, dangers, control, treatment, education. 65p.

Addiction, Crime and Social Policy — Baridon, Phillip C. Lexington Books, Toronto, 1976. Overview of opiate addiction and crime, addicts, research findings. 126p. $16.10.

The Effectiveness of Drug Abuse Treatment. Volume 4: Evaluation of Treatment Outcomes for 1971-1972 DARP Admissions Cohort — Sells, S.B., and Simpson, D. Dwayne (eds). Ballinger Publishing Company, Cambridge, 1976. Figures, tables, references, index. 483 p. $22.80.

The Scientific Study of Marijuana — Abel, Ernest L. Nelson-Hall Publishers, Chicago, 1976. Pharmacology, reported experiences, effects on hunger, sensory effects, time distortion, memory, psychomotor skills, psychological effects, adverse social behavior. 299 p. $15.

Drug Experiments on Prisoners: Ethical, Economic, or Exploitive? — Myer, Peter B. D.C. Heath and Company, Toronto, 1976. References, index. 131p. $14.85.

Sleep Disturbance and Hypnotic Drug Dependence — Clift, Anthony D. (ed). Excerpta Medica, Amsterdam, 1975. Appendexes, index. 352p. $43.10.

Psilocybin: Magic Mushroom Grower's Guide — Oss, O. T., and Oeric, O. N. And/Or Press, Berkeley, 1976. Bibliography, glossary, illustrations. 63p. $5.45.

How to Control Your Drinking — Miller, William R., and Munoz, Ricardo F. Prentice-Hall, Inc., Englewood Cliffs, 1976. Setting limits, self-control, drinking situations, alternatives, appendexes, index. 246p. $4.50.

The Peyote Dance — Artaud, Antonin. Farrar, Straus and Giroux, Inc, New York, 1976. Translated from the French by Helen Weaver. 105p. $2.75.

Alcohol Enforcement Countermeasures — International Association of Chiefs of Police, Washington, 1976. Alcohol and alcoholism, research on alcohol abuse and highway safety, problems encountered by police, enforcement of alcohol safety. 234p. $3.10.

The Gemini House Manual: A Comprehensive Primer on Drug and Life Information — Gemini Collective. Gemini House, Champaign, 1976. Stimulants, depressants, other drugs, first aid, life information. 160p. $5.

Prescription Drug Pricing: "The Politics of Pills and Profits" — Missouri Public Interest Research Group, St. Louis, 1975.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements as early as possible to: The Journal, 33 Russell St, Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

Society for Neuroscience 6th Annual Meeting — Nov 7-11, 1976, Toronto, Ontario. Information: Neuroscience Annual Meeting Office, 9650 Rockville, Pike, Bethseda, Maryland, 20014.
Detox Workers Training Program — Feb 7-11 and March 7-11, 1977, Toronto, Ontario. Information: Diane Hobbs, Coordinator, Detox and Rehabilitation Programs, 33 Russell St, Toronto, Ontario, M5S 2S1.
Canadian Foundation on Alcohol and Drug Dependencies Annual Conference — July 10-15, 1977, Winnipeg, Manitoba. Information: CFADD, 303 Kendall St, Vanier, Ontario.

US

Second National Conference on New Age Techniques for Drug and Alcohol Rehabilitation — Nov 12-14, 1976, Tucson, Arizona. Information: Mukta Kaur, 3H0 Counselor Training Institute, 1050 N Cherry Ave, Tucson, Az, 85719.
Seminar on Alcoholism — Nov 3-12, 1976, Chicago Illinois. Information: Central States Institute of Addiction, 120 West Huron St, Chicago, Ill, 60610.
Current Concepts in Drug Therapy — Nov 4-5, 1976, Seattle, Washington. Information: University of Washington School of Medicine, Division of Continuing Medical Education, E 305 Health Sciences Building, SC-50, Seattle, Wash, 98195.
American Association for the Study of Liver Diseases — Nov 5-6, 1976, Chicago, Illinois. Information: Dr S Schenker, Vanderbilt University, School of Medicine, Nashville, Tennessee, 37232.
1st National Conference on Issues in Juvenile Justice and Child Development — Nov 14-17, 1976, McAfee New Jersey. Information: Ronald Krate, Department of Psychology, William Paterson College, Wayne, NJ, 07470.
Second Annual Alabama School of Alcohol Studies — Dec 6-10, 1976. University of Alabama. Information: Peter Balsamo, Continuing Education in Human Services, PO Box 2967, Alabama, 35486.
3rd Annual Research Meeting — Alcoholism — The Search for the Sources — Jan 26-28, 1977, Research Triangle Park, North Carolina. Information: Center for Alcohol Studies, Medical Building 207-H, Chapel Hill, NC, 27514.
National Drug Abuse Conference 1977 — May 5-9, 1977, San Francisco, California. Information: NDAC-1977, Haight-Ashbury Training and Education Project, 409 Clayton, San Francisco, Cal, 94117.

Abroad

International Conference on Alcoholism and Drug Abuse — Nov 20-25, 1976, Baghdad, Iraq. Information: International Council on Alcohol and Addiction, Case Postale 140, 1001 Lausanne, Switzerland.
7th International Conference on Alcohol, Drugs and Traffic Safety — Jan 23-28, 1977, Melbourne, Australia. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.
Cruising Medical Seminar on Alcoholism — Feb 26 - March 5, 1977, Caribbean cruise aboard Cunard Countess. Information: Center for Alcohol Studies, Medical Building, 207-H, Chapel Hill, North Carolina, 27514.
6th International Conference of the World Union for the Safeguard of Youth — May 31 - June 4, 1977, Geneva, Switzerland. Information: World Union of Organizations for the Safeguard of Youth, 28, Place Saint-Georges, F-75442, Paris, Cedex 09, France.
23rd International Institute on the Prevention and Treatment of Alcoholism — June 6-10, 1977, Dresden, German Democratic Republic. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.
7th International Institute on the Prevention and Treatment of Drug Dependence — June 13-15, 1977, Dresden, German Democratic Republic. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.
International Medical Symposium on Alcohol and Drug Dependence — Aug 21-26, 1977, Tokyo and Kyoto, Japan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.
1st International Conference of Social Pharmacology — June 1977, Jerusalem, Israel. Information: Stanley Epstein, 113/41 East Talpiot, Jerusalem, Israel.

OPINION

BY PHILIP VARGAS*

Death by aerosol

INDIRECT INHALATION by industrial workers of the vinyl chloride contained in some spray paints has recently been recognized as a major industrial health hazard.

But, the intentional, and at times sustained, inhalation of toxic and volatile hydrocarbon solvents and fluorocarbon propellants from aerosol and spray products by adolescents and pre-adolescents (some as young as six years old) remains virtually unknown and even ignored.

Periodically there are reports of children who sniff one type of aerosol or another with fatal results. Many have died as a result of accidental suffocation from the plastic bags used to enhance inhalation of the vapors — usually after intoxication.

An equally real and less visible danger to youthful experimenters and chronic abusers may lie in the lingering and long-term effects from ingested chemicals or metals which the body is incapable of excreting (such as copper, lead, zinc, or vinyl chloride) and which remain, possibly to cause manifest harm in later years, with such effects as terminal cancer, chronic zinc or copper poisoning, or gradual brain damage. The consequences of aerosol or spray paint highs may not always be immediately fatal, but inhalation of these highly toxic chemicals and metals by children may have gradual but permanent physiological effects.

THE BACK PAGE

Among American youth, preliminary data suggest there is, nationwide, deliberate inhalation and/or ingestion of highly toxic chemicals and metals contained in common aerosol dispensers.

(In Canada, any completed surveys on the extent of inhalant abuse have been limited by various drug agencies to local geographical boundaries. No data have been collected yet on a nation-wide basis — although there are sketchy reports of inhalant abuse in all parts of the country at different times and in varying degrees of severity).

The aim is to achieve a "high" and the practice is widespread among all socio-economic groups and not, as some have believed, concentrated among lower class, racial-ethnic groups. Class differences that do exist tend to relate to extent of abuse, and the type of products used to achieve intoxication. For example, spray paint inhalation is found to be extensive among lower and working class groups, whereas deodorants, frying pan, and hair sprays are used more among the middle and upper classes.

Indications are that deliberate inhalation of aerosol fumes (mostly metallic paints, hairsprays, deodorant, and frying pan sprays) is a widespread problem among young people — potentially the most dangerous and damaging drug problem today.

Why?

- The highly toxic composition of substances used in aerosols, such as zinc, copper, vinyl chloride, and lead, inhaled in high concentrations and for prolonged periods, poses a high risk of serious and irreversible physical harm.
- The products are inexpensive, legal, and easily available in retail stores and homes.
- The abuse is engaged in by the very young who are often inexperienced and unaware of the consequences.
- The problem of aerosol abuse has been almost totally neglected by drug and health agencies.
- There has been inadequate research and data to define the scope and nature of the problem.
- There is evidence that violent and aggressive behavior is associated with this type of drug abuse activity.
- There is evidence that aerosol substances may serve as a drug of initiation and lead to progressive drug career patterns.

A basic point to be made is that those who inhale toxic substances or so-called industrial solvents do not any longer, for the most part, sniff glue or paint thinners.

"The kids have gone on to harder and more deadly stuff," one observer of the problem has stated.

Thus, while paint and aerosol inhalation seems to be increasing, glue sniffing is on its way out. One important reason — in addition to user preference for the more potent spray substances — may be the controls imposed on the sale of plastic cements in neighborhoods across the United States.

An interesting aspect of this problem is an official confusion with the term "glue sniffing" as a youthful recreation which is rapidly outgrown. Such a concept of the inhalant and/or volatile substances issue has tended to relegate this problem to the status of a low-priority, non-problem, and has prevented serious attention to the inhalation of toxic aerosol chemicals and heavy metals contained in spray paints.

Statistics regarding the dimensions of this problem are difficult to find. Most of the empirical evidence available comes from a small number of studies by local groups attempting to estimate the incidence of abuse in their locales. Most research and literature, however, is concerned with sniffing of plastic cements and glues — the popular problem of the late 1950s and 1960s.

There have been some early public warnings about the aerosol sniffing problem. A page one article in *The New York Times* on July 20, 1971 titled Aerosol Sniffing: New and Deadly Craze, stated: "Physicians, government officials, drug experts and chemical manufacturers are growing increasingly worried about a deadly and relatively new drug abuse problem among the nation's children: the inhalation of aerosol sprays." However, little has been done in terms of policy. One reason may be that the emphasis has been squarely on hard-drug addiction, and other drug abuse problems were neglected.

According to one observer, "non-opiate abuse has been around for a long time, but the heroin problem was partly a public relations, Nixonian law and order trip and ignored what the real drug problem has been."

A 1974 study of 1,176 students by Chicanos Unidos at three high schools in a low income section of El Paso, Texas, revealed that "between one and two-thirds of all junior and senior high school aged youths had reportedly used spray paints."

In Phoenix, a 1972 survey done by the US National Institute of Drug Abuse funded drug abuse program there, Valle del Sol, found that "the rate of incidence of paint and glue inhalation among Phoenix Inner City youth showed that approximately 12.55% of the youngsters in the Inner City had sniffed paint or glue . . . and that the first experience of paint inhalation occurred at the average of 9.6 years, or while they were in the third grade".

A questionnaire answered recently by a sample of college students in New Mexico showed 14.2% had inhaled one sort of volatile substance or another on at least one occasion.

In Fresno, California, a drug use survey conducted in 1974 revealed 22.6% of rural and urban youth interviewed had deliberately inhaled metallic spray paints for intoxication. The study reported: "Whereas the sniffing of glue, aerosol deodorants, and the products sprayed on frying pans has been widely reported, the use of metallic spray paints exceeds that of all substances for 'sniffing' in this community (Fresno)."

A series of articles in *The Baltimore Sun* (June 1 and 2, 1975), by Robert P. Wade describes how teenagers in that city "gather with plastic bags and spray cans full of paint and ignition spray looking for their dreams." According to Mr Wade, "large numbers of them (mostly lower class white youths) are doing it in areas of Southeast Baltimore, in Southwest Baltimore and, to a lesser extent, in Hamilton and Remington." The Baltimore Police arrested 544 persons last year for inhalation.

The Sun followed up with an editorial (July 14, 1975) wherein it was stated: "Providing medical treatment for huffers (inhalers) has low priority in state drug abuse programs because, in the view of officials, its ill effects are mitigated by the fact that most who try it give it up at age 15."

This official view, of course, ignores the potentially serious social, psychological, and physical damage that can affect young people inhaling these substances in the first place. As *The Sun* editorial further noted: "It also ignores the fact that psychological problems that lead to drug use usually can be treated more easily in childhood than later."

The only other statistics on the magnitude of the problem in Maryland, according to *The Sun*, are either questionable or just not available. Certainly, the author of this article has found it difficult to obtain data to assess the incidence and scope of the problem.

However, estimates by reliable observers in New Mexico, California, Texas, Colorado, Arizona, and Maryland range from hundreds to thousands of youngsters in each of these states who inhale one type of aerosol product or another, but mostly spray paints. The estimates received were as follows.

- **El Paso, Texas:** A juvenile probation official stated there is "a minimum of 7,500" youngsters who inhale in that city.
- **Pueblo and Denver, Colorado:** Project Adelante, Inc., a youth drug abuse prevention program exclusively dealing with inhalant abuse, estimated "8,000 repeated spray paint and aerosol sniffers in Colorado".
- **San Diego and Los Angeles, California:** Dr Marco Infante of Multi-cultural Drug Abuse Prevention Resource Center in Inglewood, California said: "There are no less than 6,000 kids that sniff in southern California and the figure could be much higher, maybe 15,000."
- **Albuquerque, New Mexico:** According to LaVerne Wardlow of the Drug Abuse Education and Coordination Center: "There are anywhere from 1,800 to 2,000 kids that inhale in Albuquerque alone." An estimate of 10,000 was considered reasonable for the entire state, which has a majority rural population.
- **Tucson, Arizona:** According to Manuel Zapeda, in charge of the inhalant abuse component of the youth service bureau in that city: "We currently have a load of 250 inhalers in the program . . . and this is for only one out of eight sections of town. There must be close to 2,000 kids that sniff in this city."
- **Baltimore, Maryland:** According to the author of a series of articles on the inhalation problem in Baltimore, Robert P. Wade: "There are hundreds of kids doing it in this city, maybe even thousands."

The lack of commercial or legal controls on products so used, and their availability, makes for the opportunities for widespread abuse.

But, school officials, juvenile probation and court officials, community drug abuse and welfare workers, and about 60 youthful inhalers in these states, all suggest there is substantial evidence of inhalation abuse in every community.

Reports of aerosol and spray paint inhalation have also come from other parts of the country — from Puerto Rico, New York, New Jersey, Michigan, Kentucky, South Dakota, Wisconsin, Ohio, Illinois, Oklahoma, Montana, Florida, and Maryland.

The problem is not new. In 1970, 110 teenagers were reported to have died as a result of deliberate inhalation of aerosols. All occurred in predominately suburban, middle income, white families involving a variety of popular deodorants, frying pan sprays, and hair sprays. According to one report, by "November 1971 the number of tragic deaths had risen to 171."

That report cites other examples of deaths of youngsters involving a variety of commonly available spray can products.

Because of the extreme dangers it bodes for young abusers, attention to this problem is of special urgency.

** Mr Vargas is a Virginia-based lawyer and management analyst and former university professor who has studied inhalant abuse independently in addition to serving as a private consultant to the US National Institute of Drug Abuse and the State of Arizona Division of Health Sciences.*

— Gail Geltner

Lower pot penalty has minor effect

By John Shaughnessy

TUCSON — As long as the offence of simple possession for cannabis use exists and is enforced, efforts to reduce the social costs of criminalization upon young people by reducing the severity of non-prison sentences may have little effect.

Patricia Erickson, a researcher in criminology at the Addiction Research Foundation of Ontario says "the social effects of the effort to decriminalize cannabis use by means of substituting discharge for conviction appear to be negligible".

Although she stresses her analysis is still preliminary, in her opinion the type of sentence is not a major determinant of the social outcome of the offender.

Speaking to the annual meeting of the American Society of Criminology here, Ms Erickson described a Toronto study of the direct social effects on the cannabis user who is detected and labelled a criminal.

The study group consisted of 95 people who were found guilty of simple possession of cannabis in the summer of 1974, and were interviewed at court immediately after sentencing.

Twelve months later, 85 of the original sample were re-interviewed. Sample members were predominantly young single males with incomplete secondary schooling. More than half reported long-term heavy use (twice a week or more) of cannabis. Over two-thirds were employed, mainly in semi-skilled or unskilled work and nearly half still lived at home with parents.

At the original trial, 42% of the sample received an absolute discharge, 34% a conditional one, and 24% were fined. Similarly in the followup group, 40% had received absolute discharge, 36% a conditional one, and 24% a fine.

The social costs considered by Ms Erickson included: loss or impairment of vocational and employment opportunities, disrespect for the police and the law itself, a sense of injustice, response of parents, deterioration of family relationships,

(See—Varied—page 12)

Köp hem alkoholfritt för tomtar som kör

Sweden's Systembolaget (liquor board) is promoting dealcoholized drinks in all stores. And to set an example for the festive season, Swedish citizens are told Father Christmas (above) drinks dealcoholized drinks.

NZ doctor spotlights 'futile' law

AUCKLAND, NZ — A New Zealand doctor has defied a subpoena to appear as a witness in a prosecution for excess blood alcohol because of his concern about the "complete futility" of the country's law on alcohol and driving.

Henry S. Wilcox, a Rotorua police surgeon, acted to draw attention to the increasing number of drunken drivers discharged this year because of legal technicalities.

No action was taken by the magistrate, who dismissed the defended blood-alcohol case without prejudice.

The chairman of the local branch of the New Zealand Medical Association said the branch fully supported Dr Wilcox because the law as it stands does nothing to reduce the road toll.

Because of loopholes in breath-testing regulations, drivers with high blood alcohol levels frequently avoid conviction. Others have had convictions quashed on appeal.

Merry Christmas!

The Journal

PERIODICALS READING ROOM ... Humanities & Social Sciences

Vol. 5 No. 12 | Published monthly by Addiction Research Foundation | Toronto December 1, 1976

Its role is 'increasingly unclear'

NIAAA must adopt a more dynamic stance

By Karin Sobota

SAN DIEGO — Instead of searching for a "magic bullet" to cure alcoholism, the American government must start paying attention to the kind of research necessary to support program delivery.

And, while the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has been instrumental in launching many aspects of program delivery within the occupational programming movement, its role over the past several years has become increasingly unclear to those in the field.

Those are the views of Paul Roman, Favrot professor of human relations, Tulane University, New Orleans, and a leading researcher of the occupational programming movement in the US.

Dr Roman believes the NIAAA must be pushed by those in the field to develop a distinctive role in "sustaining and facilitating the movement". Speaking here to the fifth annual meeting of the Association of Labor-Management Administrators and Consultants on Alcoholism, he commented:

"I think we need to demand there become a new, dynamic, and clearcut involvement on the part of the NIAAA. I'm not suggesting the kind of role for NIAAA we sustained and carried out in the past.

"I think we're past the time where a big grant program, which is based upon whoever gets their applications in on time — and if the applications are written out in the correct bureaucratic fashion — are those who are the sole recipients of funds," he said.

"Large scale grants have been shown, in many instances, to bring about more trouble when they run out because of the level at which they were originally funded. I would not advocate a movement in that direction."

Dr Roman suggested a carefully planned program of research and demonstration projects, addressed to key issues which have been identified by people in the field, is "badly needed." In addition to supplying this service, the NIAAA should start providing mechanisms for the professional development of new and existing personnel in the occupational programming movement.

"I see from my perspective a need for some form of national or regional professional development centres staffed by persons of the highest quality," he said, "to begin to move this field at least in the direction of some form of professional recognition."

Dr Roman also emphasized a need for a network of qualified consultants to provide technical assistance to those groups which are not beneficiaries of federal funds.

"I would think it would be very cost-effective for NIAAA to provide funding for people to travel within their own particular region or local area to assist people who are trying to get started."

Finally, Dr Roman saw a role for the agency to develop an effective vehicle for communicating innovations and trends in the field to its participants.

"We need at least to consider the possibility of getting NIAAA back in terms of a clearcut role and in terms of the kind of role that facilitates our activities."

Smoking ban is plaguing Ottawa

By Bryne Carruthers

OTTAWA — Canada's capital has the questionable distinction of having the toughest anti-smoking regulations in the country and perhaps on the continent.

The distinction is questionable not because tough anti-smoking rules to prohibit smoking in most public places lack support among a growing number of people. Rather it is questionable whether the new city regulations can be enforced.

In the latter regard, the city's parking meter men and women — the infamous "Green Hornets" (after the green uniforms) — have been given the unenviable job of enforcement, sparing their seniors, the Ottawa constabulary, from another thankless task.

Private citizens may also lay charges themselves against smokers violating the new regulations by smoking in such places as retail stores, financial institutions such as banks and trust companies, reception areas, elevators, escalators, stairways, and most public buildings (including City Hall).

But the catch is that the complainant must obtain the name of the offender, and there is no law which requires the offender to provide identification or a name.

In addition, Ottawa's solicitor, Donald Hambling, has argued against such an anti-smoking crackdown on the grounds that the new regulations may go beyond the city's authority — only the courts will determine that.

Needless to say, non-smokers initially reacted with jubilance and smokers oftentimes reacted with vehemence; later the

(See — Ottawa — page 12)

The Child as Target

• Child abuse. Is alcoholism a signifigant factor in those who batter children physically and emotionally? Contributing Editor John Shaughnessy reports. See The Back Page.

• Bob Randall receives a "prescription" from the American government for a drug that will help arrest his progressive blindness — cannabis. Mr Randall's fight to get the drug legally is detailed on page 6.

Regular features

Serendipitous findings blur too many evaluations

By Karin Sobota

SAN DIEGO — Unless alcoholism treatment programs are evaluated within the confines of predetermined objectives, any conclusions reached can be less than significant to those who authorized the evaluation.

Linda J. Webb of the Texas Research Institute, Houston, told the fifth annual meeting here of The Association of Labor-Management Administrators and Consultants on Alcoholism that unless the tasks, roles, and methods of an evaluation are clearly negotiated before a study is undertaken, problems will occur.

Dr Webb referred to the study authorized and funded by the US National Institute on Alcohol Abuse and Alcoholism (NIAAA) in which the Rand Corporation examined the effectiveness of alcoholism treatment centres. The results indicated the centres were effective to a certain degree.

"So far so good. However, the study went on to indicate that some alcoholics could resume moderate drinking and maintain adequate functioning — evidence that NIAAA did not request," said Dr Webb.

"These serendipitous findings and the implications of these results were not anticipated and, as you know, have caused considerable uproar."

Another example of the need for clarification of task is shown by the Stanford Research Institute's (SRI) evaluation monitoring activities for the Industrial Alcoholism Centres. Dr Webb explained:

"NIAAA, in keeping with the times, contracted with SRI to provide a uniform data collection system for all its projects. Unfortunately, the information needs of both NIAAA and the projects were never made explicit. Thus, an evaluation monitoring system that could have been used for management purposes tended to become a ritualistic activity that provided delay information in a standardized format that was of questionable use to anyone."

Accountability to the taxpayer for federally funded programs has resulted in a great demand for evaluation of all human service programs in the US in the last 10 years. The funds devoted to this research by the federal departments of health, education and welfare, and housing and urban development, have increased 30% between fiscal years 1971 and 1973, according to Dr Webb.

Although there is a distinct mandate to conduct this research, there are a number of options as to how it is carried out, she said: the evaluator may assume the role of researcher to conduct a scientific investigation of a particular phenomenon; may become a "politician" to provide a funding source with evidence of a program's success; or act as a collaborator with the project's management for planned changes in the effectiveness of the program.

"With proper negotiations regarding the task of the evaluation, the role of the evaluator, the methods of evaluation, and consideration of the possible consequences of the results, the likelihood of accomplishing the goals of the evaluation will be maximized and the experience should be far more rewarding for both parties," Dr Webb concluded.

It's not how much that counts

How an alcoholic drinks is critical

SAN DIEGO — Defining an alcoholic by how much he drinks is a bit like measuring frequency of sex in rapists as a criterion of reform.

It's not frequency of sex that's the rapist's problem, but his pathological style of engaging in it which must be identified: the same principle applies to an alcoholic's relation to liquor.

The "how" of drinking and not the "how much" is the critical factor in determining whether a person's relation to alcohol is normal or pathological, according to Douglas Chalmers, associate professor of psychology, school of social sciences, University of California, Irvine.

Dr Chalmers said evidence of a recovered alcoholic's morbid concern for control and not the quantity and frequency of drinking should be used when conclusions are being made about his success or failure in treatment outcome studies.

He criticized all treatment evaluation studies — including the Rand Report (**The Journal**, August) because: "It turns out everybody (in the field) draws conclusions from defective research and publicizes them. Furthermore, if you look through the literature, you find that research method is the best predictor of treatment outcome — the worse the design, the better the likelihood of positive results."

Dr Chalmers outlined the specific inadequacies he saw in the studies at the fifth annual meeting here of the Association of Labor-Management Administrators and Consultants on Alcoholism.

- All studies were done while the alcoholic was back in the community after treatment — when he was most likely to be apprehensive about being evaluated on his drinking behavior.
- Evaluators were usually the same people who treated the alcoholic. "Interviewers can unconsciously bias questions and answers whether or not they have a vested interest in the outcome, and subjects who are apprehensive about being evaluated will produce biased answers."
- The concept of "test-retest-reliability," or, "if you ask him twice how much he drinks, will he give you the same answer both times?" — has never been done on alcoholics at time of follow-up.

Of all consumption measures, only one — a non-consumption measure — is reliable, said Dr Chalmers. He supported the validity of continuous abstinence on the basis of a study he conducted, where more than 90% of ex-patients who claimed continuous abstinence were consistent between two interviews with this fact corroborated by their spouses.

AA expects more women next year

By Jean McCann

CLEVELAND — An upcoming survey of Alcoholics Anonymous membership is expected to show an increase in the percentage of women coming into AA in North America.

"The survey (to be conducted next year) should show a major change in the number of women in AA," John L. Norris, chairman of the General Service Board of Alcoholics Anonymous of the US and Canada, predicted here.

"This has been a real trend, and we expect it to continue," Dr. Norris said here during a symposium on alcoholism which was sponsored by the Cleveland Academy of Medicine and Women's General Hospital.

"Our last survey in 1974 showed that 31% of the people coming into AA were women, and I'm sure that it's now higher than that."

Dr. Norris said that he expected more young people will be shown to be members of AA in the new study, and that it will show a continuing improvement of the relationship of AA with the medical profession and other outside organizations.

The AA official said the study will be made by giving questionnaires to people attending meetings at a random sample of AA get-togethers in North America. Questionnaires will be filled out anonymously.

In the last survey, he said, 14,000 questionnaires were returned. He said that survey showed that AAs needed both medical care, and AA, to recover from alcoholism.

Dr Norris is the head of a board which includes 21 members, and one of seven who are not alcoholics.

"It's interesting that when the board of trustees first formed, nobody had had more than three years of sobriety in AA, and they didn't trust themselves, and didn't trust each other, in the money department. So the initial board was made up of a majority of non-alcoholics. There were eight non-alcoholics, and seven alcoholics, up until 1962."

BC shuts down counselling for some old-time addicts

VANCOUVER — Long-time heroin addicts with "no measurable motivation" to be cured will be shunted into a new no-counselling methadone maintenance program under the British Columbia Alcohol and Drug Commission, it was announced recently.

Commission chairman Bert Hoskin said the pilot program will "free counsellors so they can concentrate on those addicts who have motivation to overcome their addictions".

One of the city's five existing methadone maintenance clinics will be converted for the project, which was set to start by Dec 1.

There will likely be about 70 addicts in the program, although the number could be larger if addicts are attracted by another feature of the program: the lengthy five-day urinalysis procedure to confirm addiction will be dropped in favor of a rapid narcotic challenge diagnosis.

The clinic will use naloxone, a narcotic antagonist which produces symptoms similar to withdrawal when administered to an addicted person.

The program will be voluntary, he said, and addicts who develop "measurable motivation" will be able to transfer to one of the other clinics.

"The project is for the old-timers who have been addicted for many, many years and for those who have a long history of relapsing.

"Success will be measured in terms of whether or not they cheat and remain a burden to their community or whether they can get some stability in their family relationships."

Guyupta gets the answers to alcoholism

By Wayne Howell

THE NICE thing about being a developing nation in a strategic location is that the great powers are ever eager to lend a helping hand whenever and wherever they can.

Guyupta is one of those lucky nations; the small island republic lies in the sea of Ranipuro, controlling access to the oil-rich Gulf of Zandimur as well as to the highly prized Straights of Inju-pui. Consequently, Guyupta has no shortage of foreign advisors whose only interests are the well-being and prosperity of the Guynptan people. And consequently, Guyupta's esteemed leader General Huyo, who holds the title President For Life — And Even After, knows well the major capitals of the world where he has received 21-gun salutes, state dinners, and other more tangible tokens of affection from other esteemed leaders.

Now at one time, before the Glorious Revolution of May 13, General Huyo was just a corporal in the Guyuptan home guard and, at that time, he thought that only in Guyupta was alcohol a social curse. His foreign travels soon disabused him of that naive notion. There were as many glassy eyes in Moscow as there were in Washington as there were in Guyupta.

This puzzled General Huyo and so he was always asking questions. One day, for instance, he asked the American psychologist working in the Guyupta school system why there was such a problem with alcohol in a developed country like the Soviet Union.

"It is simple," the American said, "the lack of autonomy, the dreary regimentation, and the oppressive political system drive the Russian worker to his primitive potato distillates as surely as night follows day."

This made sense to General Huyo. At least, it made sense until he asked the Soviet engineer who was constructing the deep water port at General Huyo City why alcohol should be such a problem in the United States of America.

"It is simple" said the Russian. "The lack of direction in people's lives, the lack of social purpose, and the soft life in a decadent political system drive the American masses to their effete concoctions, their Brandy Alexanders and their pink ladies, as surely as day follows night."

This made sense to General Huyo. But he was looking for solutions, not causes. And so he went back to the American and asked him why the Soviet Union, a controlled society, was not able to control alcoholism.

"It is simple," the American said. "The oppressive government knows only oppressive remedies — it jails drunks, fires workers that drink, appoints special police constables to ferret out imbibers, all in the firm but misguided belief that if you want men to do your bidding you have to stomp on them. Hard. Experience has shown that it rarely works."

That made sense to General Huyo. At least it made sense until he asked the Soviet advisor why the American government was unable to control alcohol abuse.

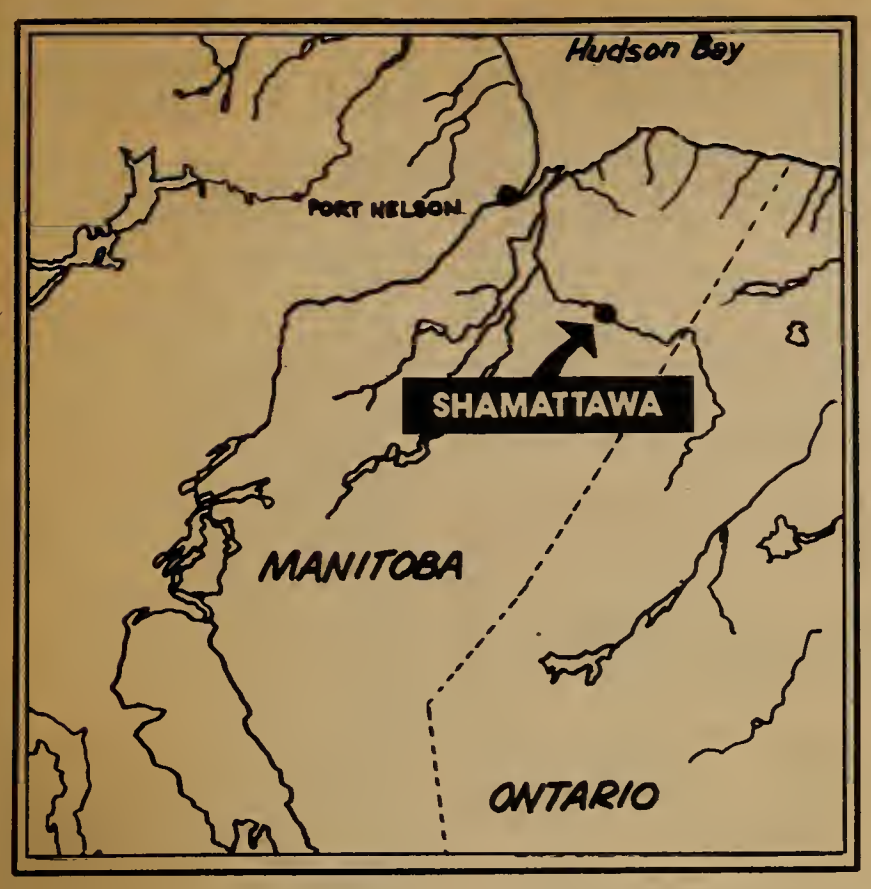
"It is simple," he said. "Soft, decadent governments apply poultices when they should lance the boil — they create more and more social agencies and hire more and more counsellors, all in the firm but misguided belief that if you want men to do your bidding all you have to do is pander to them, entreat them, and listen to their life stories several times over. Experience has shown that it rarely works."

General Huyo was at a loss to know how to proceed in Guyupta since although his government was certainly decadent, it still managed to do a good job of oppressing the people. And so he turned for advice to the Chinese ambassador who had just offered to construct for him a cross-island railway line to link General Huyo city with Huyoville on the western coast. The ambassador gave him a little red book.

"It works in China," said the ambassador.

General Huyo wanted to know how it worked, but the ambassador was in one of his inscrutable moods. And so, General Huyo went back to his Russian and American friends. They both admitted it worked, although they didn't know how or why it worked. And they were both convinced the cure was worse than the disease.

(Wayne Howell is an Ottawa physician and freelance writer.)



Gas-sniffing native children keep going back for more

By Manfred Jager

WINNIPEG — This city's largest health institution, the Health Sciences Centre, continues to battle a continuing addiction problem involving children from a northern community which has been plagued by youngsters gasoline sniffing.

Five children treated for severe lead poisoning in the Health Sciences Centre this fall were among a group of 60 Shamattawa, Manitoba children treated here last spring for the same condition.

Roger Boeckx, assistant director of clinical chemistry at the hospital complex, said three of the five children under treatment this year for three and four months resumed gasoline sniffing as soon as they were returned to Shamattawa.

Shamattawa is an Indian community of 550, about 230 miles north of Thompson, Man.

Dr Boeckx said he found the five poisoned children on a recent visit he made to the community to test 85 youngsters. Levels in excess of 80 micrograms of lead per 100 millilitres of blood were found, the chemist said. Health officials consider 40 micrograms a permissible safe level.

Dr Boeckx said it had been recommended that all children with lead levels considered toxic be brought to Winnipeg for treatment but some parents refused to let their youngsters make the trip.

"The parents didn't want them out of the community — they just are not prepared to let these kids go again," said Dr Boeckx.

Three of the five children who did come to Winnipeg have been released from hospital to foster homes. There they will continue to take prescribed drugs which bind the lead and allow it to be passed out of the system. The children will receive regular medical checkups until the lead in their blood falls to a safe level, Dr Boeckx said.

In April, two Shamattawa children died of pneumonia related to lead poisoning.

Their deaths triggered a trip by Winnipeg doctors and other health workers to Shamattawa to test several hundred people in the community for lead levels in their blood. Sixty children were subsequently brought to the city for treatment.

However, this meant a loss of 15% of all youngsters in the Shamattawa community, and caused sufficient shock among the adults to make them try to control the gasoline sniffing problem.

Part of this effort was the establishment of a four-member community patrol that tracked down gasoline sniffers and reported them to their families or to the band council. The band also opened a drop-in centre and expanded its recreation program. (**The Journal**, August).

The plan seemed to work well during the summer. When the children returned from Winnipeg in August, however, concern about glue sniffing fell off. Dr Boeckx said the return of the children from treatment in Winnipeg also meant many of the ring-leaders were back in Shamattawa, ready to resume their former habit.

The children continued to sniff, according to Dr Boeckx, because "they were having a good time".

He added: "I asked one little boy why he sniffed. He said he did it because when he did he walked funny, like his father."

Dr. Boeckx said the problem was probably related to the Shamattawa alcoholism problem. "Some health officials are very concerned we are being a revolving door for this thing.

"We don't want to get one of these kids down here in a box some day and unless something is done to get to the root of the problem we're afraid that's what will happen."

Band council members agreed early this month to have two community workers brought to the settlement.

The workers will be responsible for planning activities at Shamattawa's drop-in centre and will also provide group and family counselling services, Ron Wally, regional director for the Non-Medical Use of Drugs Directorate, said.

The new project will be sponsored jointly by the federal department of Indian affairs, and the medical services branch and Non-Medical Use of Drugs Directorate of Health and Welfare Canada. Representatives from the three agencies will act as advisors to the band council as long as the gasoline sniffing problem continues.

The community workers were to be selected by the end of November and will be signed up for two years. They are expected to train eight people from the community to take over from them when they leave.

The trend's to resist

'Facts' need challenging

By Karin Sobota

SAN DIEGO — The Rand Report. Much has been said and more will be — in the field of alcoholism, at least — about the notion some alcoholics can resume "controlled drinking".

But the report itself is just one example of "a distinctive tendency to resist research findings that challenge various assumptions," according to a researcher in the occupational alcoholism field.

"We have so many assumptions, so many notions, that have slowly become engraved onto stone, as if they were facts, as if they were scientifically proven points, and the longer that goes on without questioning, the more difficult it is to challenge those assumptions," said Paul Roman, Favrot professor of human relations, Tulane University, New Orleans. He was speaking at the annual meeting here of the Association of Labor-Management Administrators and Consultants on Alcoholism.

Dr Roman criticized "big bosses" in the alcohol field who show their "disrespect" for alcoholic people by trying to protect them from temptation — such as reading the Rand Report.

"(This) represents in many ways the kinds of resistance we have for dealing with data in a rational fashion. I'm not defending the Rand Report," he said, "but I think what is interesting is the kind of attention it has demanded in light of the many other concerns which I think probably would be a better use of our time."

Within the occupational alcoholism movement specifically, Dr Roman questioned the assumption that on-the-job supervisors must all take part in comprehensive training to familiarize themselves with alcoholism and other behavioral problems, and then be able to spot them in an employee the next day or three years later.

"Are we impeding the number of programs to be adopted by telling employers that several hours of training for all their supervisors and stewards is an essential part of implementing an occupational program?"

Dr Roman suggested a series of program monitors, working in conjunction with the alcoholism program coordinator, be stationed strategically throughout an organization or company and be readily available to supervisors who needed assistance.

"You could easily impose responsibility on a relatively small set of program monitors, much more easily than you could make a big, coercive statement saying every supervisor in the place is responsible for handling a case properly or he is going to be regarded as an inactive supervisor."

Dr Roman said professionals in occupational alcoholism programs avoid being critical of each others.

"Alcoholism for many years was not dealt with and the feeling (has evolved) that anybody helping an alcoholic person is better than nobody helping an alcoholic person.

"I think the time has come when those of us who think we have good ideas and think that other people have bad ideas should start being a little aggressive about it," he said.

Fat people switching from uppers to 'cocktails'

By Jean McCann

LAS VEGAS — The use of d-amphetamines and other drugs for the treatment of obesity appears to be falling out of favor.

But the potential for abuse of these drugs does not seem to be the principal reason, according to physicians attending the annual meeting of the American Society of Bariatric Physicians.

Rather, it's the new popularity of the protein-sparing modified fast, a "diet" in which the fat person avoids ordinary food entirely, and gets his nourishment from a 300-calories-a-day "cocktail" containing a small amount of protein and no calories. People on such fasts don't need drugs, it seems, to curb their appetites.

"People who are obese are poor dieters, but they're good fasters", explained Dr Peter Lindner, of the Lindner Clinic in South Gate, Cal. "This protein-sparing modified fast permits them to lose weight rapidly, and without losing lean body mass. Under ordinary fasting, lean body mass would be lost, along with the fat."

Interviews with a number of doctors attending the meeting showed that while some are still relying heavily on drugs, others use them sparingly and try to avoid "hooking" patients.

In fact, doctors belonging to the society, the only official board for those who specialize in the treatment of obesity, seemed slightly insulted when the matter was brought up.

"There has been abuse of amphetamines, but not usually by the physician", said R. E. Dietz of Harrisburg, Pa., chairman of the American Board of Bariatric Medicine. "This is more on the street. First of all, most of our doctors don't use amphetamines too much, and when we do it's in a minute amount, and we keep good records."

Dr Dietz said that physicians treating the obese, as a group, far outnumber the comparatively small number (45 in the US) who are now certified by the American Board of Bariatric Medicine.

However, he said, ethical obesity specialists still have to keep a close watch for patients wanting pills, rather than a diet.

"You can almost pick these people out. I got a call just the other day from a woman who said her doctor was sick right now, and she was a weight patient, and she just wanted to come in for amphetamines. I stopped it right there, because I told her she couldn't do that, she'd have to come in first and have a complete physical examination. That usually scares them off."

Leonard H. Stoll of Los Angeles, another bariatric specialist, said he also sees a pattern in patients who want pills, not diet.

"They will lie to you, when you ask them how many other doctors they've been to, and when they were in a diet program last. They'll swear they've never taken these pills before.

"But then they'll come back and say 'Doctor, this pill just isn't working,' and you'll know they've built up tolerance and been on the drug before, because when you start out, you'll start them on something mild."

Dr Stoll said this type of patient also will claim somebody stole their purse with all their pills in it and so "you'll have to give me some more".

BC pubs have spirits

VANCOUVER — British Columbia hotel owners are stocking up on liquor dispensing equipment in anticipation of a relaxation of laws regulating drinking in beer parlors.

Currently, only beer, wine, and cider may be sold in hotel pubs, but the owners are expecting the government to proclaim liberalizing legislation passed last year under the former New Democratic Party government.

The owners are optimistic that their traditional support of the Social Credit party and sympathy for the past bad year will sway the government.

Local bar dispensing equipment firms say some hotels have already placed orders for automatic dispensing equipment.

Men docs beat women Mds in US quit-smoking stakes

ST PETERSBURG BEACH, Fla. Women physicians — and nurses — are lagging behind male doctors in giving up smoking.

The latest American Cancer Society figures show that about a quarter of female nurses and doctors smoke as against only 19% of male physicians.

"The women apparently do not do as well as the men do and I'm not sure why," Lawrence Garfinkel, vice president for epidemiology and statistics of the American Cancer Society, told **The Journal**.

"It may be more of the studies on lung cancer were done in men, so women are not as concerned about it. Or it could just be a sex difference that is unexplained."

He also noted an association between the amount smoked, and the ability to quit.

Of the group of doctors as a whole who were still smoking — women and men — he found that 70% were smoking a pack or more a day.

No-nonsense addict program gives up and quits

By Tim Padmore

VANCOUVER — X-Kalay, one of British Columbia's most successful programs for drug addicts has folded.

It officially closed its doors Oct. 31, weakened by flagging enthusiasm, squeezed by financial problems, and bled to death by a swarm of competing agencies offering easier although sometimes less effective programs.

That was the epitaph pronounced by departing executive director David Berner, who founded the agency 10 years ago.

Today, he said in an interview, there is "a regular midway of social services".

"Here's all these booths, with colored balloons and little post-pubescent social work grads saying 'Step right up, let me help you.' "

Addicts, reluctant to make personal commitments and accept responsibility, circulate from agency to agency, moving on when the demands become too great, he said.

With "infinitely more ways for client to cop out," it became a problem holding clients in X-Kalay's no-nonsense program, he sighed.

The organization ran two restaurants and a pen company which provided employment for addict and ex-convict members.

"We just set up places where the rules were no drugs and no violence and told the people to work and stick to the rules or get the hell out," said Mr Berner.

"And it worked. It put literally hundreds of people back into the community."

And, incidentally, saved taxpayers about $4.5 million, he said — the difference between the cost of the program and what it would have cost had the people it helped gone back to the BC Penitentiary.

X-Kalay, which means "unknown path" in the Kwakiutl Indian language, was set up when a group of BC Pen ex-cons asked the Company of Young Canadians to provide a volunteer worker to set up a half-way house. They chose Mr Berner.

Now after 10 years, he said, he is just too tired.

"You have to be hero, father figure, confessor, transference object, friend, therapist, cop, and ass-kicker and you have to be that many hours a day," he said.

With Mr Berner's decision to leave, the end was inevitable.

Architect Geoffrey Massey, chairman of the board of directors said:

"The board looked around to see what we could do to find another executive director and we came to the conclusion that X-Kalay was a one-man organization and without Berner it would founder.

"It's characteristic of these sorts of treatment centres. They revolve around a personality. It's not in their nature to train a successor."

He said X-Kalay's assets have been liquidated and used to pay off outstanding debts.

But, if operations had continued, that might not have been possible. The organization had recently been losing about $4,000 a month.

The problem was the loss of a $11,000 grant from the BC Alcohol and Drug Commission.

The official reason given was that adequate services were being offered by the commission's own programs, but Mr Berner blamed the action on a tradition of bad feeling between himself and commission chairman Bert Hoskin.

Mr Hoskin said: "As a different approach to heroin dependency, I would never fault them for that. But somehow they couldn't find it to live within the fiscal and administrative requirements."

But Mr Berner said the financial problems were not the deciding ones.

"We had a couple of plots cooking which might have pulled us out, and anyway not having government money put some piss and vinegar into the thing."

Mr Berner said for the future he is toying with the idea of a career in public affairs broadcasting or acting.

"The only honest thing left for a man to do in this culture is stand-up comedy," he said wryly.

The Vancouver Resources Board has paid to send 12 of the 15 members of the Vancouver X-Kalay to Winnipeg to join the organization's surviving branch there.

Employee assistance programs

Some pioneers recount struggles

By Karin Sobota

SAN DIEGO — The job was turning some susceptible employees into alcoholics, so the Hughes Aircraft Company of Culver City, Nevada — founded by the billionaire of the same name — decided to help them.

The Western Electric Company, which did four billion dollars worth of business in the United States last year, took a look at its own situation some years ago: one of its employees jumped off a fire escape to his death, another blew his brains out, and another suffered a fall on the job and died of brain damage. Again, the problem was alcohol abuse.

For both companies, the answer seemed to lie in the establishment of an employee assistance program. To jump from the problem both companies faced in setting up the programs to their eventual successes, Western Electric is proud of its 85% recovery rate, and Hughes Aircraft has lost only 85 of the 1,300 cases it's handled in the seven-year history of the program.

It was a relatively simple concept: get the problem drinker back on the job, and the company, too, will benefit from increased productivity.

The problems encountered by the people attempting to set up the programs at Hughes and Western and in large and small, unionized and non-unionized, companies in North America and around the world were, and still are, large. One of the biggest hurdles has been convincing management the concept is worthwhile.

As James Farrell, director of administration and services, division aerospace groups for Hughes Aircraft, told the fifth annual meeting here of the Association of Labor-Management Administrators and Consultants on Alcoholism: "Most people felt don't bother treating alcoholics. If they can't do their jobs, let's just get rid of them and get somebody else that can."

Twenty-five years ago, when Howard Hughes ran the company, said Mr Farrell, he appeared very loyal to anyone who had ever worked for him. Although he finally stopped appearing at Hughes Aircraft in his "white tennis shoes, beat-up old hat, and crummy old car" to enter renowned and lengthy seclusion, many employees still considered themselves "untouchable" and protected.

"It put supervisors in a very difficult position. We had some very frustrated supervisors that felt they had a lot of untouchable people and they would cover up and cover up for a problem. Some had alcohol problems."

Today, said Mr Farrell, most of the "key people that run the company are PhDs in engineering. Their lives are highly structured and highly organized and they feel they are personally very disciplined. "So the feeling at Hughes, Mr Farrell explained, was that engineers were "too smart" to become alcoholics.

That wasn't the case. "We have engineers who are not too smart to become alcoholics. We probably have the same percentage of engineers who have been part of the caseload as production workers, or females, or minorities.

"We have a couple of very high visibility marketing people with a drinking problem and the management could see the job content and the nature of the job had contributed to this. In a way, we had helped get these guys where they are, and we ought to help get them out if we can . . . That really was the beginning of the program," said Mr Farrell.

For Western Electric, acceptance of the program is now running about 50%, according to Tom Kniebbe, installation manager, southern counties, southern California. But 10 years ago, when the program was being developed, it took union-management, cooperation and understanding.

Wells Fargo, a multinational banking organization with 250 branches in California alone, was also slow to accept the philosophy of employee assistance. When it did, the program consisted of two counsellors in one small office and a single telephone: it didn't ring for a week.

When the first call for assistance finally did come in, said Tom Campbell, one of the two counsellors: "It was a supervisor on the other end who said 'I've just fired this guy for drinking. Do you want to talk to him on the way out?"

The program at Wells Fargo has come a long way since that small beginning.

"We now have closed the loop with an employee assistance program so we can give professional assistance to every manager and supervisor with any kind of a performance problem," according to Mr Campbell.

For all three firms, lessons have been learned along the way. For Western Electric, lesson number one was realizing company supervisors can't be made experts on alcoholism.

Said Western's Tom Kniebbe: "I think the program works in our company because it's simple. All we have to do is tell a supervisor to do his normal supervisory job. We don't have any magic answers, we don't have any magic formulas for him. We're saying, watch his work performance, watch his absenteeism, watch his production. If it changes, why?

"One thing that we have to caution our counsellors about is not to see a drunk under every rock."

Visibility of the contributions of an employee assistance program — in whatever department it happens to be located — is extremely important, according to Mr Farrell.

Top management must continue to be aware of the contributions the program makes, and while confidentiality between the problem employee and the counsellor is strictly observed, management should know the program is "paying its way" in the number of employees assisted.

Caterpillar Tractor, which is now also implementing assistance programs in its overseas operations, employs 80,000 people. On the basis of an average salary of $12,000 there is a potential saving of $3,000 for each case.

John Clarno, coordinator of special health services for Caterpillar, emphasized the importance of visibility on an international as well as local level.

"I think wherever that program has to exist, it has to exist with enough visibility and with enough administrative clout not only to implement it, but to sustain it. And I think that force can come from a joint base."

For Western Electric, that joint base includes union involvement and, although a long way from reality, Mr Kniebbe said he would like to see an employee assistance program written into the union contract.

"A lot of people are going to die when they hear I said that. The union is interested in people and when you get it in a contract, you have got to do something; you've got to spend the money."

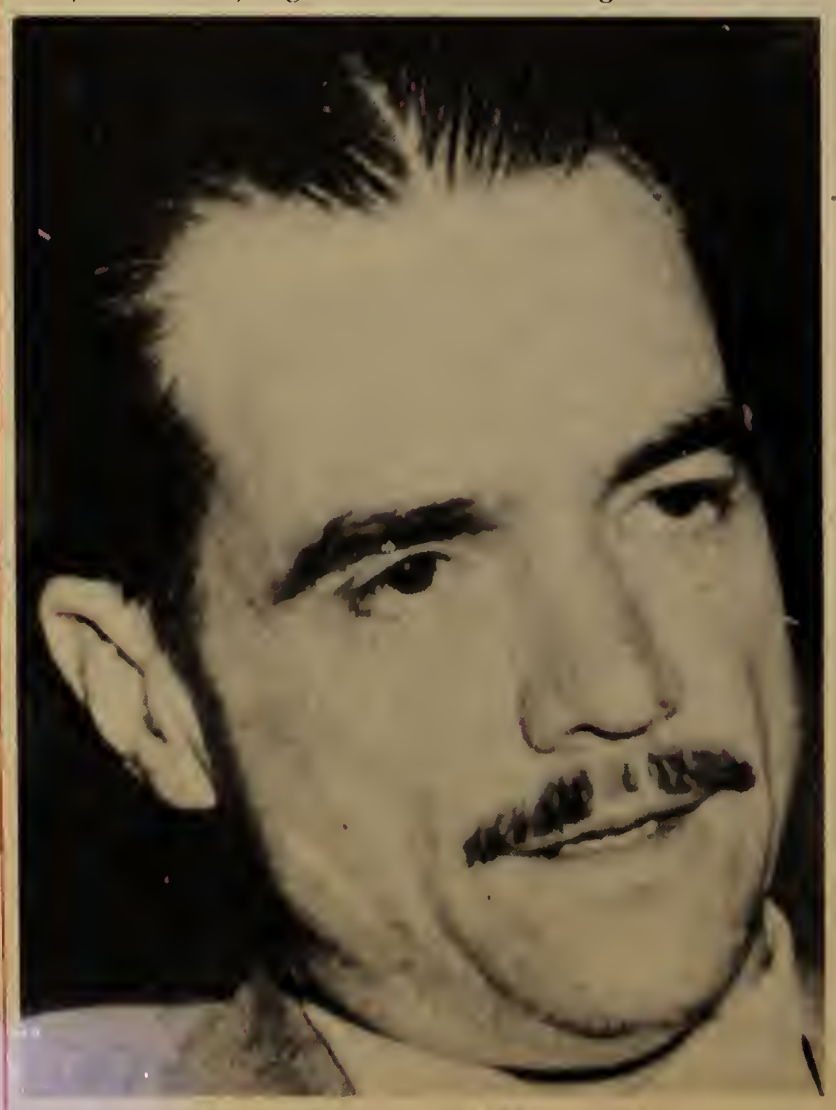
Mr Farrell disagreed.

"I feel employee performance is a management perogative and I think a counselling organization that would encourage the union to take this program over, or be a part of it, or bargain with it, is working against the purpose of what the program is trying to do."

Morris Cummings of the Member's Assistance Program, United Labor, in Kansas City, Missouri criticized present company policies regarding union involvement:

"Seldom does one find the so-called labor population in a non-organized work place being included in the planning, development, implementation, and operation of a program. In unionized places, it is popular to elicit the union's support, but this solicitation quite often denoted cooperation or no objection from the union."

In the past, the mystique of Howard Hughes and men like him protected both manager and employee from many realities. Today, industry is realizing what it costs in both human and financial terms.



Howard Hughes without 'the beat-up old hat'.

Taxes hiked

LONDON — Another big chunk of taxes may be taken from British drinkers.

As the pound plummets and Chancellor Denis Healey is thought to be considering more austerity measures, the situation looks gloomy. Since he came into office Mr Healey has raised taxes on alcohol by a staggering 285% since 1974.

The Wine and Spirit Association says the taxes have cut wine sales by more than one million gallons and liquor sales have fallen by more than 1.4 million gallons.

'Leaving Marlboro Country'

Jis' gimme m'hoss and m'oxygen tank

By Harvey McConnell

LONDON — Tough cowboys deliberately modelled on the Marlboro image — except that they are either dying or are crippled ex-smokers — featured in the latest of a number of highly successful British television programs about smoking.

Impact on viewers has been enormous, both on the commercial network and on the British Broadcasting Corporation.

Death In The West was the fourth program in 18 months by reporters Peter Taylor and Martin Gilbert for This Week, a prime time current affairs program on the commercial network, on the dangers of smoking.

During this time, independent Gallup polls have shown that 750,000 viewers have given up smoking directly because of the programs and another three million are trying to kick the habit.

Earlier in the year, a give-up smoking campaign on the BBC's daily Nationwide program (**The Journal**, April) reported similar success in helping people stop.

Ironically, the latest This Week program was made because a representative of Phillip Morris — Marlboro has a minute one per cent of the UK market — approached the This Week team and invited them to film in America. The company said its interpretation of the health evidence was different.

Company spokesmen put forth their point of view. But, the British reporters found Marlboro-image cowboys suffering badly from their years of smoking.

The most telling shot was of a middle-aged cowboy riding on the range — with oxygen bottles strapped to his horse and a plastic tube up his nose for his chronic emphysema.

Mr Taylor admitted that two years ago he was a light smoker and knew little about the real dangers of smoking until chided by his friends in the medical profession.

When they decided to do their first program in April 1975 — and not without opposition from many television colleagues who smoke — they felt they had to say to their regular 15 million viewers: "Look, if you smoke you have a choice. It is not just a question of getting a bad cough, or possibly bronchitis, it is the statistical possibility of your killing yourself."

Their first program, Dying For A Fag, told the story of a 42-year-old smoker dying from lung cancer.

A Gallup Poll immediately afterwards found that 160,000 viewers had stopped smoking instantly and another four million intended to do so.

A week later, in Licensed To Kill, This Week looked at the responsibility of the government, the advertising industry, and the tobacco industry.

Mr Taylor pointed out that then and now the British tobacco industry, despite repeated invitations, has steadfastly refused to have a spokesman appear.

Six months later, Mr Taylor talked to four smokers who had given up the habit following the earlier programs. This time a representative from J. Walter Thompson Advertising Agency appeared on the program and attacked all of the statistical evidence linking smoking and lung cancer.

Mr Taylor admitted they had found it difficult to make four programs getting the same message across because of the in-built resistance of many smokers to being told "what, by and large, he doesn't want to hear."

Martin Gilbert said that the residual effect of their first program "has been quite remarkable. We still get requests asking if the program could be repeated as the writer is tempted to start smoking again and wants to see what made him stop in the first place."

He added: "There is no doubt about it, the British tobacco industry is fighting scared. It is the only industry in the country that I know of that is totally unprepared and unwilling to defend its product.

"Over the past two years, I find myself becoming more and more angry with the British tobacco industry and the advertising industry as there seems to have been little change."

Mr Taylor commented: "We like to think that our contribution, if any, is that we have changed the way the issue is regarded by the media."

Danger in the operating room

Alcoholics are at risk in surgery

By Jean McCann

CLEVELAND — Surgeons have to be careful to find out if the patient is an alcoholic, before they operate.

Maxwell N. Weisman, director of the Alcohol Control Administration for Maryland, issued this warning here during a talk at a symposium on alcoholism which was sponsored by the Cleveland Academy of Medicine and Women's General Hospital.

Patients have "died on the table", he said, when this alcohol dependence was not known.

"We know that the alcoholic becomes cross-tolerant to other sedative drugs," Dr Weisman said. "There is cross-addiction, and cross-tolerance. And this applies to the patient who has become addicted and dependent on alcohol, even though he may have stopped drinking on admission to the hospital. This patients may go into *delirium tremens* on the operating table.

"There is also another complication, in that he is tolerant to greater doses of anesthetics before being anesthetized, and therefore the margin of safety is reduced. Unless one is very careful, and aware of the fact that this patient is an alcoholic, and carefully monitor the margin of safety, some patients will die on the operating table."

Dr Weisman said he has no figures on the incidence of this, "but even if it's a low percentage, it's unnecessary and should be looked into."

The likelihood is, he said, that this may occur rather often. "Knowing the incidence of alcoholism, which is very high, and knowing the way in which it is constantly ignored, misunderstood, or undiagnosed, it's quite likely that the anesthesiologist or surgeon is unaware of it. Another problem is that alcoholics will deny or minimize their alcoholism, and unless there is more careful history-taking than is usually the case, it will be missed.

In the hospital, Dr Weisman said, the doctor can either cope with the problem by withdrawal under appropriate sedative medication, or by consciously watching for the danger signals on the operating table.

Dr Weisman said that the extent of this danger in the operating room is also shown by a study in his state of the underdiagnosis of alcoholism, which confirmed an earlier study done in Boston.

"In Maryland, we did a study on one of the wards, and we found that, indeed, patients who were alcoholic were admitted under a variety of other medical diagnoses. Alcoholism was not diagnosed, even though, on interviewing the patients, we did find that 40% of them could be diagnosed as being in some stage of alcoholism, early or late."

Dr Weisman said that physicians in hospital rarely diagnose alcoholism, unless the patient is obviously a skid row derelict. If the patient still had a family, was brought in by his wife, and was white, he was not diagnosed for alcoholism. Often he was diagnosed "fever of unknown origin".

Another reason for "undiagnosis", he said was found in the Boston study and "was appalling . . . if the drinking pattern of the patient resembled the drinking pattern of the doctor, he was not diagnosed as an alcoholic."

There's an art to history-taking

CLEVELAND — There's an art to taking a good "drinking history" of medical patients.

Gregory Collins, director of the Alcohol Rehabilitation Center at Cleveland Metropolitan General Hospital, offered this advice to a recent symposium on alcoholism sponsored by the Cleveland Academy of Medicine and the Women's General Hospital:

"The best way to approach this is not to ask the patient how much he has been drinking lately. You'll get a spurious response, like 'a couple of beers a day', or something. It's much better to approach it from a chronological standpoint, and work this into your general history and review of systems."

He suggested that the first question might be When was your first drink? followed by discussion about changes in the drinking pattern. Such questions may be asked as: And where did your drinking go from there? After you got out of high school? How often was this? Did drinking cause you to get in trouble with the military?

How about marriage? Have you been divorced and remarried? Has drinking had anything to do with the breakup of your first marriage?

Dr Collins also suggested asking questions about legal infractions, such as arrests for drunken driving.

He said this line of questioning gives doctors a good idea of whether the individual has suffered complications in any area of his life as a result of excessive drinking.

"The alcoholic is quick to point out that various areas of his life are not affected by his alcohol," Dr Collins said.

"He's quick to focus on the areas that are not affected. Your job is to focus on the ones that are affected. The assumption is that if he is drinking despite serious consequences to any area of his life — whether it's physical, emotional, legal, or financial — the assumption is that this is an alcoholic drinking. Otherwise he wouldn't do it."

Dr Collins said ideally the drinking history should be obtained when the patient arrives with a medical complaint, or during a medical crisis.

"Get it right then, rather than admit the patient to the hospital and wait until he's feeling better, because then it will be easier to deny it. On the other hand, if he's in front of you in his pain and misery, his defences are down, and he's very likely to be more honest."

USSR/Interpol mystery

LONDON — British police and customs officials are mystified by reports that Interpol — the international cooperative police network — has helped the Russians to nab several Britons for trying to smuggle cannabis through the country.

Russia is not a member of Interpol and does not receive any police information. No requests about Britons convicted of drug offences have been made to Scotland Yard.

Officials believe the Russians — who have handed out hefty jail sentences in recent months to Westerners caught with drugs in their baggage — are letting rumors of Interpol assistance go unanswered so that they can hide their source of information. The most likely sources are thought to be arrested addicts or carriers.

Kiwi smokers chuffed

AUCKLAND, NZ — Even smokers have welcomed a Wellington hotel manager's decision to ban smoking in one of his bars. Since bringing in his "smokeless zone", Bill Brien has received several letters and telephone calls of support.

"The reaction is great," says the former police officer, a non-smoker himself. "Even the smokers are chuffed (delighted), because all smokers have a desire to give up."

Five provinces hanging back on spot checks

By Bryne Carruthers

OTTAWA — The federal government's roadside spot checks plan for drinking drivers has been extended to three more provinces and to the two federal territories, effective Nov. 1.

But five provinces — British Columbia, Manitoba, Quebec, Prince Edward Island, and Saskatchewan — have still not joined the ranks of governments taking advantage of the federal government's attempts to get even tougher with impaired drivers.

Ontario and Alberta were the first not only to bring the legal changes into effect, but also to equip and train their police to enforce the changes — specifically the application of the roadside breath checks.

The key to the tougher impaired driving laws is that policemen in the participating provinces and territories now have the right to demand breath samples at the roadside if a driver is merely "suspected" of driving a car with alcohol in his or her body.

As envisioned by federal justice department authorities, this change will allow police to set up spot checks near favorite watering holes and nab clients as they drive away.

The roadside spot check is limited to culling out drivers close to or already beyond the legal blood alcohol limit of 0.08% which defines impaired driving. People selected must be taken to a police station for formal breathalyzer testing, still the only basis for a formal charging and possible conviction under the law.

While a driver may not be charged or convicted solely on the basis of the roadside checks (which feature use of a portable breath reading machine), any driver refusing to submit to the roadside check faces the same penalties as a driver who refuses the more formal police station breathalyzer test.

Classic medical approach ineffective

Barriers separate alcoholics from doctors

By Dorothy Trainor

MONTREAL — Hidden communication barriers between the alcoholic and his doctor that militate against the diagnosis of alcoholism and its treatment is the theme of a McGill University study.

"The doctor's method of approaching the questioning and the offering of aid is the crux of the whole matter," principal investigator Henry B. Murphy told registrants at a Clinical Aspects of Alcoholism Day at Montreal General Hospital.

"What I want to make clear is that the approach to the problem is not the conventional one of medical deduction. The recognition and diagnosis of alcohol abuse is less a problem of perception and logic than a problem of social interrelationships," said Dr Murphy, professor of psychiatry.

Also, unlike other medical problems, the doctor's approach to that recognition and diagnosis will greatly influence the probability of successful treatment, he said.

The patient should never be asked 'Are you or are you not an alcoholic?'.

"We found that to label the problem as 'alcoholism' is dangerous because it enables both doctor and patient to avoid further action."

When the alcoholic is so labelled, he explained, he can counter, "An alcoholic! I'm not there yet!" This reply relieves both doctor and patient of further questions and answers.

To explore what doctors should or should not be doing when faced with the alcohol abuser, Dr Murphy set up a research study on the hidden barriers in their communications.

A 13-item questionnaire was distributed by members of his research team to average patients in general practitioners' offices and hospital clinic waiting rooms. Alcoholic clinics were avoided as being atypical for the purpose.

The questionnaire dealt with the patient's recent worries regarding drinking habits, hangovers, etc. Almost 500 patients completed the forms while waiting to see their doctors.

After the card had been completed and the patient had seen his doctor, where relevant, both doctor and patient were interviewed to find if the subject of drinking had come up and what was said.

Psychoanalysts were also questioned to ferret out the dynamics of the hidden barriers under study and there were interviews with former and current alcoholics and their doctors.

What the researchers found was that alcohol abusers rarely seek help and information regarding their drinking usually comes from other sources. Patients deny their drinking problems and conceal information, so the diagnosis of alcoholism is very often missed.

"Our data were quite close to that of David Robinson's UK study that showed that only 17% of alcoholics were recognized by clinical examination."

Results in the McGill study revealed that of the almost 500 respondents to the questionnaire, just over 10% (51 people) saw themselves as having trouble with alcohol. It was also shown that:

- Only 5% of these asked for help regarding drinking habits;
- 49% revealed the problem without asking for help,
- In 46% of cases, the matter was not mentioned at all by either doctor or patient.

Why the high number of people revealing a drinking problem without asking for help?

"The answer is linked to why they drink," Dr Murphy said. "There is a close relationship between drinking and the gratification of a need for a sense of power and a sense of self determination. Drinking can lull feelings of low esteem. To admit his drinking problem to the doctor is to admit his weakness. Further, such admission leads to submission to the doctor's directives."

That low-image patient wants to feel in control when he enters the doctor's office, Dr Murphy added, because of his inability to accept his self image.

How should the doctor approach his problem-drinking patient?

The doctor is most likely to achieve communication with a patient if he can convey the idea that the patient himself is the authority.

"Don't question his authority. The decision to stop drinking is his.

"Say to him, 'All right, you are concerned about your drinking, but I cannot know you as you know yourself. I am merely somebody who has certain advice and can direct you to mechanisms whereby you can help yourself."

That sense of remaining in control may strengthen the patient's self confidence, Dr Murphy said. But the classical medical approach which is "You have a disease and I know how to treat it" will get little response until — possibly — the patient has reached the "too late" stage

Gov't supplies pot to man

By Mary Hager

WASHINGTON — Bob Randall is confronted with an agonizing dilemma: go blind or be a criminal.

Mr Randall is suffering from severe open angle glaucoma, an irreversible disease that cannot be cured but sometimes can be arrested. Conventional drugs have not helped him, but marijuana has, which accounts for his dilemma.

The federal government has recognized the therapeutic benefits of marijuana in Mr Randall's case and given him permission to smoke in a carefully controlled research program.

He received his first "prescription" for marijuana in mid-November and is now able to smoke government-produced cannabis without threat of legal action.

In order not to jeopardize his supply, Mr Randall is heeding government orders not to discuss how much and how often he receives the drug.

But, at the same time, he is awaiting a decision on his trial last July in District of Columbia courts for possession of marijuana. If convicted, he faces up to one year in jail or a fine of from $100 to $1000.

Mr Randall, 28, and a former speech teacher, is legally blind in his right eye and has severely impaired vision in his left. He discovered quite by accident several years ago that smoking marijuana made the hazy rings he saw around lights disappear.

He didn't know then that he had glaucoma. He thought it was just eye strain.

At the same time, some medical researchers were suggesting that delta-9-tetrahydrocannabinol, or THC, the active ingredient in marijuana, may be effective in a number of diseases, among them glaucoma. Apparently

Bob Randall

the active ingredient acts to reduce pressure within the eyes.

Mr Randall felt he needed to be able to control both the quality and quantity of the marijuana he used, so he began growing his own, discreetly, on a second floor sundeck. But his plants were seen from a distance by police making a routine investigation in the neighborhood. His current legal problems stem from this chance sighting, for he chose to fight rather than give in.

Last December, he participated in a marijuana research study at the University of California, Los Angeles, where researchers "found smoked marijuana to provide him with a significant reduction in IOP (intraocular pressure).

"Marijuana's pressure-lowering effect, in combination with prescription medications, usually brought his IOP levels toward the normal range. It appears that marijuana in smoked form afforded Mr Randall IOP reductions of positive therapeutic value ... Mr Randall would benefit from access to marijuana of controlled quality and quantity for medical purposes."

Based on this, Mr Randall petitioned the federal government to permit him to smoke marijuana legally. The request was granted, thanks to a proposal for research on marijuana and glaucoma received from Howard University at about the same time. Now he is able to smoke government-produced marijuana as part of a controlled research project.

But, he is still frustrated by the attitude of the local government. "They argue that eyesight is not an inherent right," he notes. "I say if it's a choice between my eyesight and the law, I leave it to rational people to determine which choice I make."

Extent of industrial concern is seen

By Karin Sohota

SAN DIEGO — Fewer employees than expected have been referred to counselling services within their companies, according to a preliminary report on a survey of the extent of industrial alcoholism and drug abuse programs in the United States.

Marshall J. Gohy of Lutheran General Hospital, Park Ridge, Illinois, and William J. Filstead, department of psychiatry, Northwestern University Medical School, Chicago, told the fifth annual meeting here of the Association of Labor-Management Administrators and Consultants on Alcoholism the initial results of the survey. It is believed to be the first national survey of its kind.

Questionnaires were mailed to the 3,200-member American Occupational Medical Association and the results presented to the ALMACA meeting represented an initial return of 400 replies from physicians at the same number of companies.

Based on the number of employees who used a company grams, 21 of whom were referred for inpatient services, 22 for outpatient services, and 17 of whom were presumably judged not to need these services.

"Those physicians that responded appear to work for companies who have a demonstrated and long standing commitment to helping employees deal with these chemical misuse problems," Drs Gohy and Filstead reported to the meeting.

"We had expected a high number of employees to have come in contact with these programs in the course of 12 months. The figure of 60 employee contacts per year appears to be significantly under what one might expect, based on the size of the companies, their length of time providing these services, and the established estimate of 5% to 10% of the work force being involved with these difficulties."

Fifty-eight of the physicians who responded worked in a manufacturing concern and almost 30% of all companies had 15,000 or more employees.

On average, each of the companies' medical departments employed seven doctors full time, but only 42% indicated having a full time counsellor or program representative in the firm. Generally, programs were most often located in the medical departments (73%), followed by the personnel, labor-relations, and other departments.

Eighty per cent of the physicians indicated they had an established company policy for dealing with alcoholism and chemical dependency and 72% indicated the company had an identified program to deal with these problems. Established programs had existed for an average of nine years.

Of the respondents who indicated no policy for an employee assistance program, slightly less than half (44%) said they were planning on developing them. The remainder (56%) who had no such plans, however, represented "very large and nationally known companies".

"This makes us wonder about the extent to which industry clearly understands the seriousness of these problems," said Drs Gohy and Filstead.

High-rise depression

Hundreds of children are on anti-depressant drugs because of the pressures of "high rise" living in Walsall, a borough located in the English Midlands. With a population density of 270,000 housed in 3,500 apartments, it is estimated that one in every 10 children is on drugs to ease the pressures of crowded living conditions. Couples must have two or more children before they are allowed to move from the crowded apartment towers to more spacious quarters.

Publishers worried by alcohol ad limits

OTTAWA — The Canadian Daily Newspaper Publishers Association has warned about the dangers of having the federal government decide what type of lifestyles advertising of alcoholic products should be allowed, especially as lifestyles are always changing.

The warning was a reaction to federal health minister Marc Lalonde's stepped up campaign to eliminate lifestyle alcohol advertising — something Mr Lalonde has described as particularly offensive.

As might be expected, the CDNPA has suggested self-regulation would be the best solution to alcohol beverage advertising. The association further suggested the government encourage the Canadian Advertising Board to consider assuming responsibility for establishing a tripartite committee (made up of industry, consumer, and media representatives) to establish advertising standards to be used as a measure for actual advertising.

The association opposed proposals to limit budgets of newspapers for alcoholic beverage advertising. (Interestingly enough, the federal government's $650,000 advertising campaign against irresponsible drinking is using the printed media, mainly the large daily newspapers.)

It also described as "utterly impractical" government proposals to establish time deadlines or time bans for alcohol advertising on television. Meeting such deadlines for a live sports event being broadcast in Canada's five different time zones would be difficult, for example.

The association argued there is no evidence that advertising leads to or contributes to alcohol abuse and that controlling advertising for a legally-available product, even by imposing government definitions on allowable lifestyle ads, would entail risks too great for any freely-elected government to take.

The association has no general objections to proposals for labelling alcohol bottles and containers with warning labels about a potential health hazard, similar to the warnings now required on cigarette packages.

Near-beer takes 6% ale sales in Alberta

EDMONTON — Low alcohol brews already account for more than 6% of Alberta's beer sales volume, and a provincial spokesman has predicted the market will continue to grow.

The first such products were sold through the government-run Alberta Liquor Control Board about four years ago, and now four major breweries — three of national stature and one regional firm — produce low-alcohol beer. In Alberta, it contains 3.9% alcohol by volume, compared to about 5% for standard beer.

An ALCB official said that during July, a high-volume month for beer sales, about 200,000 cases of low-alcohol beverage were sold through government stores and private-enterprise licensed facilities. He said the popularity of low-alcohol beer seems to be increasing rapidly now.

The provincial liquor outlets sell low-alcohol beer for $3.15 per dozen bottles while the standard product goes for $3.75, although the wholesale price paid to breweries is identical. Malt beers sell for $4.05.

Brewery-run bottle return depots pay 60 cents a dozen for empties in refillable condition.

A liquor board official says the lighter beer is comparable to many brands sold in the United States. He was doubtful the new product has done much to curtail alcoholism, although theoretically the lower alcohol content makes this a possibility.

Many of the low-alcohol drinkers imbibe sparingly and only occasionally anyway, he suggested.

Alcoholic's thinking problems

Recovery may be very long process

CLEVELAND — The "cerebration defect" from alcohol can often be recovered from, but it can take an amazingly long time for such recovery — even years.

This comment, to a symposium here on current concepts in alcoholism came from the chairman of the General Service Board of Alcoholics Anonymous, John L. Norris.

In an interview with **The Journal**, Dr Norris said the thinking deficit lasts a surprisingly long time. "The person who opened my eyes to this was a 29-year-old man. When he came in to see me a month after he first talked to me, and I'm sure he was totally abstinent in this first month, he told me that it had only been in the last three days that he'd been able to think the way he used to. And he was only 29 years old.

"Since that time", said Dr Norris, "I've asked that question of many who have recovered either in AA, or in some other way, and the estimates will run usually from a year to several years. The longest is seven years.

"I was talking just last week to a man who has a very responsible job in an international company, who told me that he'd been dry seven years, but he only began to be aware of adequate functioning after five years, and 'now I know I think better than I ever did'."

Dr Norris said the mental deficit appeared to be across-the-board, rather than pinpointed in any one area, such as ability to solve complex problems. Included in the thinking problem, he said, is "their irrational approach to the use of alcohol".

However, it also includes clear-cut thinking in general. The man who went the longest before recovering his previous skills was an accountant. He was the one "who told me that it was seven years after he'd quit drinking before he was able to handle the job".

While it is known that alcohol does damage brain cells, Dr Norris said, this alone does not seem to account for all cerebration problems. Some alcoholics who appeared to be permanently brain-damaged, for instance, have recovered after treatment and withdrawal from alcohol.

Dr Norris said the combination of cerebration problems, with denial, "makes us begin to understand how impossible it is for these people to respond to what most of us consider reasonableness. How can they be so stupid? How can they fail to recognize what's happened to them? In my judgment this is a part, at least, of the reason."

Dr Norris, one of the non-alcoholic members of the AA, stressed how important the role of the AA member is in getting such people into treatment. AA helps, he said, because it is an emotional, person-to-person approach, rather than intellectualization, which the alcoholic can't respond to.

But the AA official told physicians and others attending the meeting here, which was sponsored by the Cleveland Academy of Medicine and Women's General Hospital, that AA was by no means the answer for everyone.

"There are some people who won't accept it, as of now. There are some for whom it may not be the right answer. This is why it is important for us to know, and to understand in as great depth as we can, about alcoholism, the AA program, the people who are living and growing in the program, and to individualize our treatment program for every patient.

"All kinds of people get into trouble with alcohol. All kinds of people use alcohol to try and cope with the life. The problem as it comes to us is a combination of the person as they were in all of their relationships, what alcohol has done to them, how they've used it, and why they used it."

Dr Norris said physicians should know about the various community facilities for care, "so we can understand best how, when, and where to make the referral after we've made the diagnosis."

The AA official also suggested that doctors should know a number of AA members to which to refer patients. If they don't know them from practice, they may meet them by going to AA meetings. Attendance there is also important from the viewpoint of "hearing enough of the real story so that you understand".

Marijuana may affect sex life says new report

At least in young male rats

CHICAGO — Further evidence that marijuana may affect the male sex life — at least in young rats — has come from the American College of Surgeons.

A paper read to the surgical forum of the clinical congress of the ACS shows that young animals given tetrahydrocannabinol (THC, the psychoactive ingredient of the drug) developed smaller testes than matched controls.

Authors Drs John W. Harmon, Diana Lock, Menalaos A. Aliapoulios, and John H. MacIndoes say serum levels of testosterone and testicular levels of the male hormone were also lower in THC treated animals than in controls.

Other organs, such as the kidney, were not affected which suggests a specific effect of THC on testicular development.

"Other reports in recent literature tend to confirm that marijuana has an effect on sexual hormone balance in experimental animals. The exact physiological mechanism of this effect is not clear. Whether these phenomena which occur in animals have a major significance for human users of the drug is also unclear."

The investigators, from the division of surgery at Walter Reed Army Institute of Research, Washington, say clinical observations sparked off the work.

A letter in *The New England Journal of Medicine* by the authors three years ago described three male pot smokers who presented with enlarged breasts. The men, heavy chronic users of marijuana, sought surgical advice because they feared their breast development might lead to subsequent cancer. There have also been reports (by others) of depressed serum testosterone levels in humans and low sperm counts.

The authors previously reported that marijuana stimulated abnormal development of the breast in young male rats.

In the experiment they reported this year, rats were treated for 40 days — a period corresponding with adolescence.

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Backgrounder

BC looks to Japan for pointers

Japan's approach to heroin addicts may be a model for BC. Tim Padmore investigates.

VANCOUVER — British Columbia health minister Bob McClelland and the chairman of the province's Alcohol and Drug Commission planned last month to go to Japan for a first hand look at that country's compulsory hospitalization program for drug addicts.

The Japanese plan has been cited repeatedly by commission chairman Bert Hoskin as an example of a successful coercive program. It is likely to be an important model for the compulsory treatment program that health minister Bob McClelland promised recently to implement here (**The Journal**, November).

What does the Japanese program involve? Just how successful has it been?

Some of the answers to these questions are to be found in a report from the Japanese Ministry of Health and Welfare called A Brief Account of Drug Abuse and Counter Measures in Japan.

It was prepared in late 1975 "to give the people of other lands (a portrayal) of the actual conditions of drug abuse control in Japan," writes Akio Ishii, director of the Narcotics Division of the pharmaceutical affairs bureau of the ministry, under whose signature the report appears.

It describes the evolution of drug abuse in Japan since World War II, the tough measures the Japanese have instituted to combat the problem and, through numerous tables and graphs, documents the success of the effort.

There is one section, titled How Should We Regard the Addict, that is revealing of the cultural values that the system sprang from.

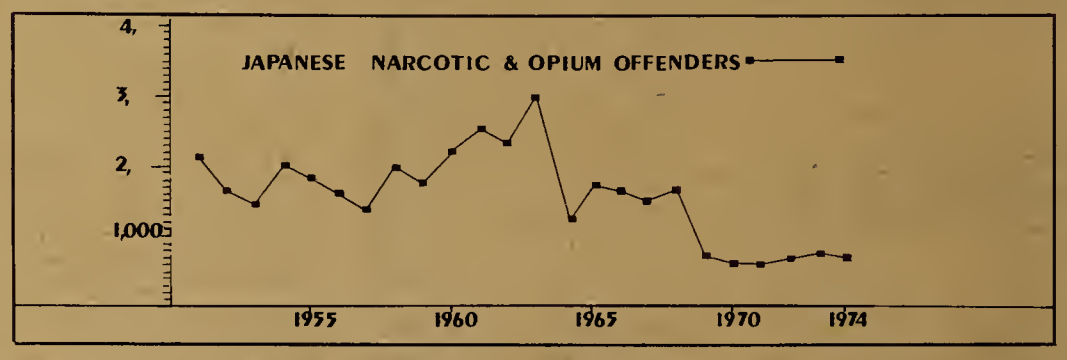
"The foundation of countermeasures against addicts is the way you perceive the addict," it begins.

"It seems that in some Western countries, addicts are seen as sick persons or even victims, and those to be blamed are the narcotics traffickers.

"Is this opinion correct? Narcotic addicts are persons who are entirely dependent on narcotic drugs; therefore, in order to obtain narcotic drugs, they do not mind disposing of household goods or losing their jobs; their sole concern is how to obtain drugs and they indulge in momentary pleasures at the expense of ambition, man's most precious quality.

"As a result, narcotic addicts become a source of other social evils including theft, violence, prostitution, etc. They destroy not only themselves and their homes, but also their country . . ."

The abhorrence of addiction is so deep



that even a patient who becomes addicted to drugs prescribed by a doctor for pain is liable to punishment — as is the doctor.

Terminal cancer is one of the rare instances in which addiction may be forgiven. But not taken for granted. Such situations receive individual scrutiny.

Before 1945, the report says, there were few addicts of any kind and those there were were mainly foreigners addicted to opium.

But, after the war, the country was swept with an epidemic of stimulant taking. Uppers were gobbled by people "forced to work desperately to make a living while in a impoverished condition".

The government slapped controls on the drugs, which had been sold without prescriptions. Smuggling flourished briefly, but further controls, including prison terms for possession and transfer, stamped that out.

At the same time, the Mental Health Act was amended to provide for compulsory hospitalization of addicts in cases where it was judged there was a danger of the addict's hurting himself or others.

The measures are credited with the reduction in the number of violators from 55,664 in 1954 to 271 in 1958.

With the decline of stimulants came a spreading heroin problem, however. By 1961 there were an estimated 40,000 heroin addicts "with heavy involvement of gangster bands".

The success of the earlier program made it clear now what to do.

The concerned ministries and police agencies formed an Anti-Narcotic Drugs Headquarters and in 1963 legislation was passed stiffening penalties — from a previous maximum of seven years to life imprisonment for heroin offences — and giving the state the unqualified right to commit addicts for treatment.

For the next five years, the picture was rosy, with heroin abuse declining significantly and a dramatic drop in the numbers of new addicts.

Since 1970, however, the abuse of stimulants has increased again, with 8,510 prosecutions recorded in 1973.

That year, the stimulants laws were toughened once more, with penalties equivalent to those for heroin offences being introduced.

The latest battle is not yet decided, for although the number of offences dropped 30% in 1974, the number rose again in the first half of 1975 and smuggling and trafficking continued apace.

The BC officials are interested in the heroin crackdown in 1963.

Under the 1963 amendments, those identified as addicts — not necessarily in actual possession of a prohibited narcotic — may be committed for one month on the basis of a diagnosis by a Medical Examiner of Mental Health.

If that proves insufficient, the term may be extended to up to six months by a five-member Narcotic Addiction Examination Committee. The average length of hospitalization is 41 days.

Treatment is followed by "observation and guidance" for five years. All people reported as addicts, not only those who are hospitalized, are subject to this long-term counselling.

After the start of the program, there was a dramatic drop in the number of new heroin addicts reported — from 1,621 in 1962 to 204 in 1964.

Much of the immediate drop was a result of a shift to other narcotics, such as morphine, codeine, and synthetics. However, by 1970 the total for all narcotics had dropped to under 100.

The report admits there may be undetected addicts but asserts that the true number is surely less than 200 or 300 new addicts a year.

There was a less dramatic but still significant drop in the number of narcotics offences. The number fell by a factor of two almost immediately, and has declined slowly since then.

About 8,000 narcotic addicts have been subjected to the law, 10% of whom got compulsory hospital treatment. Of the total, 2,643 disappeared before the five year follow-up ended and 1,441 have been discharged to society as ordinary citizens.

The report states addicts are cured "almost 100%" within two to three months and says relapses are very rare.

The treatment is based on cold-turkey withdrawal. Methadone is not used although recourse is sometimes made to major and minor tranquillizers and hypnotics if withdrawal symptoms are too severe.

When withdrawal symptoms stop, the patient gets psychological and occupational therapy. The goal is to train the

(See — Japan — page 14)

Inside Science

When is non-drug edu

By
Michael S. Goodstadt*

" 'My, my, will you look at the chairman's new drug program,' they said as they examined the new teaching materials.

'Isn't it wonderful,' some said

'An absolutely positive step in pedagogy,' said others.

'But daddy,' piped up a small child, 'the Emperor has no drug program at all!' "

* * *

Readers of Wayne Howell's satirical column in **The Journal** (May) will recognize his clever application of the tale of the Emperor's New Clothes to recent developments in drug education.

As with the use of any simile, Dr Howell's literary licence has permitted him both to clarify a critical issue in drug education and also to fall into the trap of assuming that the evident is always obviously true. The questions are: When is a drug education program a drug education program? If it is not a drug education program, then what is it?

In elucidating this issue, two dimensions will be considered: one being the affective/non-affective continuum, the other being the drug/non-drug continuum (see illustration).

An increasing number of drug education programs and curricula has stressed the role of affective factors. These factors are believed to include attitudes, values, and decision-making skills, and contrast sharply with the more specifically cognitive and behavioral elements of education.

In making categorizations along the affective/non-affective continuum, both the absolute quantity and the relative amounts of affective material *vis a vis* direct drug content are considered. At one extreme, a program can be almost entirely cognitive in its content and didactic in its process; at the other extreme one can imagine a program so affective in its content and processes that it deals only with values and feelings, rather than with what is known, for example, about alcohol use.

The rationale for this shift in emphasis rests upon: the apparent lack of effectiveness of previous efforts which have emphasized the informational and "rational" approach to drug education; and a growing appreciation for the complexity of influences on behavior. These influences include situational and social forces external to the individual, and those internal affective forces which are thought to represent how one's self, one's environment, and one's options are evaluated and integrated into one's behavior.

At the present time, it is difficult to be confident about the impact of programs employing affective materials. There is a great deal of spontaneous support from "on the job" educators, but there is almost no research evidence to support the efficacy of affective education programs in general or affective drug education in particular. This absence of evidence is compounded and supported by a general confusion in conceptualizing and implementing affective programs, especially those based on values.

The quantity of directly drug-related content programs provides the basis for a second dimension along which programs may be ordered. The obvious poles of this continuum are, at one extreme, those programs which deal directly with drugs, and at the other

Staff appointments for The Journal announced by ARF

THREE MAJOR appointments to **The Journal** have been announced by Dr John B. Macdonald, president of the Addiction Research Foundation of Ontario.

Anne MacLennan, associate editor since 1974, has been named editor, succeeding Gary Seidler.

Anne MacLennan

Ms MacLennan has extensive experience as a medical journalist in both Canada and the United Kingdom. Prior to joining **The Journal**, she was with Medical News, London, England, and later, The Medical Post, Toronto.

Harvey McConnell, for the past 10 years a medical and science writer in London, England, and for the past two years one of **The Journal's** UK correspondents, will be **The Journal's** contributing editor based in Washington.

John Shaughnessy, formerly managing editor of The Medical Post, Toronto, will be contributing editor, Toronto.

Mr Seidler, **The Journal's** first editor, and Milan Korcok, formerly a contributing editor, have resigned from the foundation and will reside in the United States.

Dr Macdonald said: "These appointments of experienced journalists arc intended to ensure that **The Journal** continues to improve its coverage of news of international significance in the field of alcohol and other drugs."

John Shaughnessy

Harvey McConnell

Editor... Letters to the Editor... Letters to the Editor

Heroin decriminalization idea is horrifying

To the Editor:

The front page article on Peter Bourne (**The Journal**, Oct.) surprised and horrified me. His suggestion to discredit equally use of heroin, tobacco, alcohol, and marijuana would only result in more use of heroin. This is implicit in Dr Bourne's own statement: "I don't think we'll criminalize or make illegal use of alcohol and tobacco. But, certainly, we are going to bring heroin and marijuana closer in line so we tend to view them in the same light."

The powerful social acceptance of alcohol and tobacco has made it impossible to reduce their consumption. The strong social sanctions against heroin have undoubtedly helped control it. This is why there are so many more alcohol and tobacco addicts, despite heroin's being much more strongly addictive.

From Dr Bourne's statements that the war against drug abuse cannot be won, and that heroin will be decriminalized, I understand he has given up all hope of ever gaining control in these areas. I consider this unrealistic as I believe control can be obtained if it is desired. In a democracy the people get what they want. If a society will not exercise controls on socially destructive behavior, it can only perish. In this sense, Dr Bourne should have stated that the forces acting to destroy the civilized world will be successful. Of course, this is just what Dr Bourne implied earlier when he said drug abuse poses a threat to the future of many small as well as established nations.

Luckily, I don't believe everyone shares Dr Bourne's very pessimistic view. I myself am very optimistic, at least to the extent that I believe people and civilizations get exactly what they want. The really important issue is what they really want. All will receive what they deserve as a result of getting what they want.

Phillip S. Duke, PhD
President and Director
Duke Laboratories
North Riverside, Illnois 60546

One additional point

To the Editor:

In the Inside Science column which appeared in **The Journal** (October), column 4, paragraph 2, line 6 should continue as follows: "received a discharge, though one in three in Ontario did so. More than half of all discharges given out in Canada for simple possession occurred in Ontario".

Pat Erickson
Researcher
Addiction Research Foundation on Ontario
Toronto

Bandido poster from UK stereotypes Mexicans

To the Editor:

To begin, I think **The Journal** is a worthy publication that needs to be read by a larger majority of the world's population. I've enjoyed the varied points of view, the informative and accurate articles and, in most issues, the fine cartoons and posters.

However, in **The Journal** (August) there appears a poster that the British Health Education Council has placed at its many British Railway sites under the auspices of HEC. The poster depicts a Mexican Bandido Type character with a gun in each hand, a sly grin, and an over-sized sombrero. I was very sorry to see this poster since it perpetuates an old negative stereotype that has been more than detrimental to the many people of Mexican descent.

I would like it understood that

(See — Seemingly — page 12)

...tion drug education?

...ms which make no ex... ...o drugs.

...ter are more likely also ...y oriented programs, ...icies to equate the two ... have outlined, and ... equate their assess... ... necessarily true that ...ng a great deal of ...tent are non-affective; ...saturated with drug ... into *either* the upper ...er right quadrants of ...or is it logical to con... ...ch regarding the value ...g education automati... ...ll affective drug edu... ...s: affective programs ...either the upper left *or* ...uadrants.

...fective drug education ... be resolved, however, ...ing the ratio of affec... ...tive material, or the ...g-related content. It is ...hat, as in Dr Howell's narrative, drug education programs with no drug content have validity and value in themselves. The question, then, is: When is a non-drug education program a drug education program? The answer is: When it is a drug abuse prevention program.

The logic of many preventive drug education programs is that by dealing with issues before they become a problem, or by developing a satisfactory foundation for decision-making and non-problem behavior, individuals will be better equipped to deal with life including matters related directly to drug use. As would be expected, such a non-drug approach, or one that pays little direct attention to drugs, is to be found more frequently in programs designed for the young, especially for the very young for whom drugs are far from being a salient issue. In affective programs designed for older persons, the drug content usually becomes more explicit and of greater quantity, although the drug issues are not always sufficiently related to the affectively based content of the program.

Unstated in the acceptance of affective drug education are many questions, including: What ages are appropriate for what forms of affective education? At what ages should drug content be introduced into programs? What is the efficacy of various affective approaches at varying ages? In what ways should drug content be integrated with the non-drug material? What are the roles and impact of non-drug education programs?

Answers to these and other questions will depend on the outcome of current and future research. Perhaps, one day, the emperor will be justifiably proud of his drug education program, and his pride will be supported by research.

*** (Dr Goodstadt is a scientist in the Evaluation Studies department of the Addiction Research Foundation of Ontario).**

Teenage girls trade sex, boys steal to get drinks in London's pubs

Photo: Scottish Health Education Council

'Girls may drink free every night of the week.'

LONDON — Many teenage girls in Britain are taking an easy path to uncontrolled drinking by trading sex for drinks.

Almost any of them may go to a pub "and drink free of cost every night of the week, using different male company," adds J. J. Gayford, consultant psychiatrist and head of the Alcoholic Unit at Warlingham Park Hospital, Surrey.

He told a Royal Society of Health conference on juvenile drinking here: "Cases have been seen of females who pride themselves on being able to drink from opening time to closing time without paying for a drink.

"Sadly, cases are also seen of young women who will even have sexual relations with men who will keep them in drinks for the night. More rare, fortunately, are cases where young women will trade sex for the price of a single drink when they are desperate."

Many young male heavy drinkers have trouble keeping jobs but are subject to pressure to drink with highly paid peer groups who may only be occasional heavy drinkers. Often they resort to petty theft to get money.

Dr Gayford said that his unit, like most others in Britain, is treating an increasing number of young alcoholics. Most of them do not present with the pattern of older alcoholics and need special selective treatment.

He continued: "If total abstinence is regarded as a criterion for treatment, their prognosis is poor. Yet if this is only seen as a step towards a more stable pattern of life, the prognosis is not so hopeless.

"Usually something can be done to improve the situation by attention to the patient's physical and mental state and by support of the social and family situation."

Dr Gayford said one of the most difficult areas in treating young alcoholics is the control of the quick temper, fighting, and self-destructive acts to which many are prone.

It is one of the most difficult areas to manage in clinical psychiatry.

He commented: "To use tranquillizers of the benzodiazepine compounds, such as diazepam, only leads to habituation. The long acting forms, such as potassium clorazepate, are safer, but can still be abused."

Behavior methods have been tried which aim at teaching the patient a series of maneuvers to prevent loss of control, and provide insight into why he loses his temper. However, "these have little meaning to an enraged young man when he is drinking".

Depressive episodes are common but need thorough investigation before antidepressants are prescribed. Periods of remorse may follow drinking bouts.

Dr Gayford said: "The best test is to remove the patient from his environment for a few days, detoxify him if need be, and see if the depression lifts. In most cases, there will be dramatic improvement with this method, rendering anti-depressants unnecessary."

However, unpredictable behavior is to be expected during this period and patients frequently discharge themselves, only to reappear a few hours later asking to be readmitted, he said.

Dr Gayford said few young alcoholics can be expected to have learned they cannot drink, unlike the older alcoholic.

"Mentally he knows alcohol in moderation relieves his anxiety. Socially he has seen both its good and bad effects.

"While he is feeling ill, abstinence will not seem unreasonable, but when faced with this social barrier for the next 50 years, it is not surprising there are second and third thoughts on the subject.

"Unfortunately, the young alcoholic has to prove to his own satisfaction that he cannot drink alcohol. Alternatively, by a long and often traumatic process, he has to learn to drink in a controlled manner."

Dr Gayford said the subject of controlled drinking is an uncharted area "with gloomy indications that only a few will succeed.

"Until it is proved otherwise, abstinence seems the only safe way of preventing further trauma from alcohol."

Few young alcoholics will achieve this with one treatment session, but most of them manage for longer periods of time with fewer alcohol-precipitated crises, he said.

Psychotropic convention hits snags

By Thomas Land

GENEVA — The new Vienna Convention on Psychotropic Substances has created a set of urgent administrative problems for the Geneva-based World Health Organization (WHO) of the United Nations.

The convention, for the control of a lengthy list of psychotropic drugs, came into effect recently after Togo became the 40th nation to sign (**The Journal**, November).

One of the criteria justifying control in the future is the decision by the WHO that "there is sufficient evidence (to suggest) that the substance is being or is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control."

How, then, is this evidence to be collected and weighed? When does a drug abuse problem cease to be a minor local matter and qualify for international action?

And what kind of a machinery should the WHO establish to enable international specialists to make prompt assessment of new evidence relating to a drug and recommend an increase or decrease in restrictions?

These were some of the questions recently considered at a Geneva conference of specialists concerned with the testing and evaluation of drugs.

The advisors, brought together by the WHO, included Dr Dennis A. Cahal, senior principal medical officer, department of health and social security, London; Dr James G. Foulks, professor, department of pharmacology, University of British Columbia, Vancouver; Dr J. Jacob, professor of pharmacology and toxicology at the Paris Institut Pasteur; Dr Eugene LeBlanc, director of the Research Branch of the Ontario ministry of health and former assistant head of the research division, Addiction Research Foundation of Ontario; Dr W. R. Martin, director, National Institute on Drug Abuse, Addiction Research Center, Lexington, Kentucky; and Dr C. R. Schuster, professor of psychiatry and pharmacology, University of Chicago.

A spokesman for the WHO explains the convention was necessitated by a serious public health and social problem created through the misuse of a large number of drugs intended for medical practice but often applied for the physical sensation or hallucinatory effect they produce.

Generally described as psychotropic substances, capable of modifying mental activity, these drugs include depressants such as barbital and methaqualone, stimulants such as amphetamines, and hallucinogens such as LSD and similar compounds. The problem of drug abuse was already enormous back in 1971 when a UN conference adopted the convention in Vienna; since then, it has quickly intensified.

The convention supplements the Single Convention on Narcotic Drugs of 1961, dealing with substances primarily of plant origin such as opium, cannabis, and cocaine. Some of these, such as morphine and codeine derived from opium, also have significant use in medicine.

Psychotropic substances sought to be controlled under the new convention "include many drugs whose medical value is indisputable and which must not therefore be unduly restricted," according to the WHO spokesman. "However, the therapeutic value and risk to public health of these drugs are less precisely definable than those of narcotic drugs."

Setting the guidelines for the administration of the new international convention, specialists of the WHO thus hold a powerful legal instrument which may be constructively applied only if they manage to agree on a fair balance between potential use and abuse of these po'ent medical tools. The Geneva meeting was called to seek a common approach to the task.

The advisory group pointed out in its recommendations that, as the WHO spokesman put it, "scheduling decisions in regard to many drugs were going to be difficult because of the need to balance the benefits of therapeutic use against the hazards to public health of clearly demonstrated abuse.

"Phenobarbital was mentioned during the meeting as an example of a drug that may have to be rescheduled as a result of experience gained since the convention was adopted five years ago. It was felt (by several specialists) that its unique position in many developing countries as an inexpensive anti-epileptic drug had been underestimated and its actual abuse overestimated."

The group recommended the establishment of elaborate advisory mechanisms — such as expert panels, consultants, and collaboration with scientific institutions — to obtain the most reliable evidence in support of its proposals to the UN Commission

Safe smoke doesn't exist: gov't official

LONDON — There is no such thing as a safe cigarette and smokers should not be lulled into a sense of security by current tests with tobacco substitutes, says Eric Deakins, a government minister at the Department of Health here.

He told a conference on smoking and the media organized by Action on Smoking and Health (ASH), that a change in public attitudes to smoking had been found in department surveys. Seventy per cent of those questioned, including many smokers, would welcome more smoking restrictions.

A ban on cigarette advertising was favored by 55% of those questioned.

Around the World

Drug runners

Law enforcement pressure in Hong Kong is forcing international narcotic traffickers to buy drugs elsewhere in Southeast Asia — and the Preventive Service is taking every precaution to ensure this trend continues. According to one police official, drug traffickers no longer regard Hong Kong as a good source of supply because it's far cheaper and safer to buy drugs in countries such as Thailand and Malaysia.

Blame mother

A West Berlin psychiatrist, Gerd Roehling, claims there are alcoholics who developed their addiction because of a specific developmental trauma; specifically they had problems with their mothers. Alcoholics are alcoholics, he claims, because for them there is an unbearable discrepancy between their idealized image of their mother and the mother she really is. Dr Roehling supported his hypothesis on a series of case histories from his practice.

Drug boom

Exports of pharmaceuticals from Britain for the first half of 1976 totalled more than £211 million — an increase of 12.7% on the corresponding figure last year. But imports at £69 million were up by 42%, giving a balance of trade surplus at £147 million, 3.4% better than the 1975 surplus at the same stage. A spokesman for the Association of the British Pharmaceutical Industry said the three-to-one ratio of exports to imports by the UK industry is still among the highest in the world.

Swedes punish addicts

STOCKHOLM — A hard line approach to drug abuse will be taken by Sweden's newly elected Conservative-coalition government.

Prime Minister Fallidin has promised a crackdown also on the situation in Stockholm where some 7,000 hard drug addicts are arrested each year.

Dr Nils Bejerot told a group of visiting British journalists that Sweden has become "the most ultra-liberalistic society since the Roman Empire".

Dr Bejerot, drug dependence expert at the Karolinska Institute in Stockholm, added: "The Labour government was consumed by the psychoanalytical mumbo-jumbo that so-called social background was the main factor in causing addiction.

"The trouble was that some of its top medical advisers had never seen a patient in their lives."

Dr Bejerot said the addict does not suffer from a disease but, in fact, enjoys it. Addiction is not a social disease but a learned condition.

A less liberal approach is needed, he added. "Punishment does not help to cure the addict, but the fear of punishment does."

British policemen or "Bobbys" don't recognize alcoholism as the illness it is, and are unequipped to deal with it, especially among juveniles, says police superintendent.

Too much parental responsibility removed

UK system nurtures young drinkers

By Harvey McConnell

LONDON — Britain's cradle-to-grave welfare state may be a major cause of its growing juvenile drinking problem because too much parental responsibility is removed, believes Superintendent Betty Reid of the London Police.

At the same time, the familiar British Bobby is not well enough equipped to deal with alcohol problems and "we are uneducated in the recognition of the dangers of alcohol".

Superintendent Reid, who is also deputy commandant of the London Metropolitan Police Training School, made her blunt assessments at a Royal Society of Health conference here on juvenile drinking.

She said: "We are very quick to stress the lack of coordination whilst driving, which often results in tragic and fatal consequences.

"We raid premises, the owners or landlords of which are flouting the law. We arrest persons who are drunk and incapable, disorderly or indecent, but what do we really do?

"We temporarily remove the problem from the community."

Superintendent Reid pointed out that police will relentlessly try and find out how anyone under 18 years and found incapable through alcohol, obtained it.

But, the young alcoholic, "is arrested and charged, appears before a court, and is punished unless he is fortunate enough to have been dealt with by a perceptive police officer and magistrate, and medical reports are called for, when treatment may be the ultimate result."

Policemen have little or no training in the recognition that alcoholism is an illness. Unless they have attended special seminars "we have very little guidance, or experience on the recognition or early signs of alcoholism".

Superintendent Reid said that in almost every young alcoholic case in which she has been involved, the offender "has come from a home where one or more parent is an alcoholic or heavy drinker. There is a pattern of emotional upheaval and an excess of alcohol available. No respect for the drug is therefore apparent."

Britain's welfare state may be the cause of much of the problem, she declared.

Conflicting advice is given to parents on how to bring up their children. One popular suggestion is to allow them to develop naturally and freely.

"Perhaps our welfare state and 'professional' bodies have removed responsibility too much," Superintendent Reid continued.

"Mothers and fathers have regularly said to me: 'We didn't want him or her to visit pubs but Miss So and So said it was best to let them find out for themselves. We knew she was professionally trained so thought she knew best'."

"What can we do to retrain parents to think for themselves? It sounds hard and callous to say stop giving them so much, but is it not part of the reason behind the apathy towards life?"

Father used to take pride in being the breadwinner, but his role has been diminished and in many cases disappeared. Should he not have some of his responsibility restored as head of the family?

Superintendent Reid said that in this way "the first step in education and control in the consumption of alcohol may be emphasized".

She said it might sound old-fashioned, "but are we any better off with our progressive attitudes? I have found no evidence of this.

"Quite the contrary, I find the family units almost non-existent."

While she sympathizes with parents, "I also believe they are opting out of their duties to show their children the way."

Superintendent Reid also attacked the apathy of so many people in Britain today to a citizen's duty and responsibility.

Often she has been on plain clothes duty in a pub gathering evidence on which to obtain a warrant. Many customers who see underage drinkers cluck "What are the police doing about it?"

But, said Superintendent Reid, never has she seen anyone draw the attention of the management to a young person who is obviously under age.

She said it is "because the average citizen does not like to interfere — let somebody else do it — it is none of my business. Apathetic? Worse than that, a total failure to accept one's responsibility, morally as well as a law abiding citizen."

The welfare state has produced many changes in attitudes towards freedom. This has led young people to today's situation where they go to pub discotheques and children of 13 or 14 years are served alcohol. Adults do nothing about it.

"Dramatic it may sound, but I firmly believe we are failing the younger generation daily, by our own irresponsibility."

99% of French youth equate drinking and virility

By Lynn Payer

STRASBOURG, France — A slide show using traumatic pictures to illustrate the effects of alcohol had more effect on the attitudes of 15- to 17-year-old students than a show using non-traumatic pictures, Gabriel Moser, a psychologist, told the Fourth National Congress Against Alcoholism here.

When attitudes were measured three months later, however, they had returned to the pre-slide show level, reported Mr Moser.

Interestingly, changes in drinking behavior appeared to be more durable than changes in attitudes: 43% of students who had seen the traumatic presentation, and 26% of those who had seen the non-traumatic presentation, said they drank less than before.

Concerning the tendeney of attitudes to return to baseline levels after a period of time, Mr Moser said: "It seems that actions should be directed at the population as a whole and not simply at students if one is trying to get a stable change of attitudes in these latter. The influence of the environment can cancel the effects of isolated messages."

The traumatic arguments were more effective with attitudes about alcohol and disease, and the presence of alcohol on the ceremonial table.

"It should be noted," he said, "that replies were unanimous for only one attitude, that concerning alcohol and virility. Nearly 90% of all subjects thought a person who can't drink isn't a man, and this attitude was not affected by our presentation."

He said the two slide shows had almost identical texts and differed only visually. In the traumatic presentation, pictures from accidents and of seriously ill alcoholics were projected. In the non-traumatic show, the same script was illustrated by statistical graphs and charts as well as pleasant or banal pictures. Fifty students saw each presentation There were two control groups.

Questionnaires measuring attitudes to alcohol were given before, immediately after, and three months after the presentations. As the act of completing the questionnaire might have affected attitudes, one control group filled out questionnaires without seeing the presentation.

A second control group completed the questionnaire only at the end of three months, to allow for changes in attitudes that might have been effected by anti-alcoholism information in the media.

Mr Moser said the two presentations had varying degrees of effectiveness depending upon the particular attitude being dealt with. Thus, the traumatic and non-traumatic presentations appeared to be about equally successful in changing attitudes concerning alcohol and gaicty, the warming effects of alcohol, and its fattening effects.

He concluded: "Anti-alcohol propaganda, to be effective, ought to attack on the one hand this link between alcohol and virility, and on the other hand, the supposed relationship of alcohol to health and friendship, themes that are responsible, in young people aged 14 to 17, for attitudes generally favorable to alcohol."

Mr Moser is affiliated with the Institut de Recherches et d'Applications en Psychologie du Travail, Paris.

Family therapy boosts cure rate

STRASBOURG, France — Intensive therapy with family members and work colleagues, used in conjunction with more traditional means of treating alcoholics, proved significantly better than traditional methods used alone, Branko Gacic of Belgrade said here.

Dr Gacic told the Fourth National Congress Against Alcoholism here that systematic inclusion of family and co-workers in the therapy of the alcoholic had given a cure rate of at least 68%.

This compared with 27% cure with traditional medical treatment; and 38% cure when institutional group therapy was added to the medical treatment.

All results were from the Institut of Mental Health in Belgrade, which opened in 1963 and whose therapeutic methods could be characterized in three eras, Dr Gacic explained.

From 1963-68, a medical model was followed, with drug and individual psychotherapy treatments. He concluded from the results of work in this period, 27% cure, that "medical measures alone are insufficient to treat and re-adapt alcoholics".

In 1968, a therapeutic community approach was used, with such activities as clubs and occupational therapy, which slightly improved the cure rate.

In 1972, still another approach was adopted, the essential being intensive family therapy. In addition, all therapeutic approaches shown to have been useful in the preceding eras — medication, psychotherapy, occupational and recreation therapy — were retained.

Such therapy of family members was compulsory, and Dr Gacic noted that "the participation of certain key people is almost essential". He also emphasized that every member of the therapeutic team must be enthusiastic.

While the official rate of success for the last approach was 68%, Dr Gacic mentioned that at present 108 of 120 patients could be considered cured, but the period of follow-up was not sufficiently long to make this assertion.

Addicts esteem self-respect, honesty: study

By Lachlan MacQuarrie

HONG KONG — Heroin addicts may not be as self-centred, individualistic, or pleasure-seeking as previous literature has indicated, according to a study here.

The study was done by James Ch'ien, Patricia Ho and Po-chung Lo, of the Society for the Aid and Rehabilitation of Drug Addicts (SARDA). It was felt a better knowledge of the value orientation of Hong Kong's addicts would help in understanding which values might require change and which other values might be reinforced in the rehabilitation process.

A Rokeach Value Survey, modified appropriately for use in Hong Kong's Chinese culture, was administered to 50 patients of SARDA's rehabilitation centre for men. Rokeach identified two types of values — "instrumental values", which have to do with modes of conduct (cheerful, obedient, ambitious); and "terminal values", which have to do with the general nature of life (freedom, inner harmony, prosperous life).

The 50 respondents were given lists of 18 instrumental values and 18 terminal values and asked to rank these in order of importance to them.

Some commonly-held views about addicts' personality characteristics seemed to be confirmed in the study. For example, "values relating to self-control, endurance, patience, and persistence were well down the list of favored characteristics, suggesting these addicts could tend to be impulsive and to live for the present rather than the future," say the authors.

They also found that even though people in the study group did not place a high value on patience and perseverance, they did rate highly such factors as recognition and accomplishment. This confirmed the unrealistic views SARDA's clients often have in such areas as job-hunting where they are frequently dissatisfied with employment commensurate with their qualifications and instead seek unrealistically high positions, say the authors.

"On the other hand, some values such as self-respect, independence, responsibility, and honesty — characteristics not usually associated with the drug subculture — were given high ratings.

"Moreover, though it is commonly believed addicts are self-centred and individualistic, it was interesting to find in this study that values associated with personal happiness occupied relatively unimportant positions on the list while those associated with collectivity (societal security, world at peace, freedom and equality) all ranked quite high on the list."

The authors believe their findings may be helpful in determining future directions for SARDA's rehabilitation program, and suggest further studies of values and value systems should be undertaken.

Varied sentences change little for pot users

(from page 1)

damage to the offenders' own identity and sense of self, concern with reactions of "significant others", and incitement to engage in other criminal activity.

In general, when the study group was divided by sentence received, she found no difference in regard to the subjects' self image, their employment situation, or their subsequent criminality.

Some variation by sentence did occur in relation to the subjects' perception of the fairness of sentence and in their presentation of self to employers.

"Those who were fined or placed on probation were more likely to consider their sentence 'more severe' and 'unfair' one year after the court appearance than at the time of it."

"They were also more negative about employers' right to know about their record than those with absolute discharges; however, they handled it differently, with those convicted and fined most likely to deny the record and those on probation most likely to admit it," said Ms Erickson.

With respect to self-image, she found at first interview, all but six of the 95 subjects said they never thought of themselves as a criminal. At followup, 20% admitted they "sometimes or often" did think of themselves in this way. "However, this self-evaluation did not appear related at all to sentence, but rather to being charged in the interval."

About 70% thought they would not be considered criminals by mothers and fathers. However, a majority of the parents had not learned about the charge. Of significant others, the police were the only group perceived by a majority of the respondents (56%) as attaching a criminal identity to them. While the study subjects may have learned the difference between discharge and conviction, they did not expect parents to make this distinction.

Although true "before and after" comparisons were impossible at time of trial, 65 respondents (68.3%) said their attitude to the police had not changed, and 30 said it had. Only one of the 30 reported a more favorable attitude since the arrest. However, Ms Erickson suggested the unfavorable attitudes to the police did not follow automatically from the fact of being charged, but depended to some degree on the manner in which the arrest was conducted by the police.

Data on the employment of the subjects did not provide strong support for the view that absolute discharge versus conviction had a significant impact on position in life, at least in the short run.

"Most of the apparent changes can likely be accounted for by the sample growing older, and their being unskilled in a tight job market," she said. The number of jobs held and length of unemployment in the post-trial year were not found to be related to sentence.

To assess any potential incitement to criminal activity, Ms Erickson chose two indicators of criminal activity in the post-trial year — the number and type of charges laid against the subject, and the self-reported selling of cannabis.

Thirty-one people had been charged with an offence in the year after their court appearance for simple possession. Only 18 had been found guilty on at least one occasion by the time of the final interview, the rest were awaiting trial or had the charges withdrawn.

Eleven subjects had been charged with predatory offences (mainly assault), but here as in the other "criminal group" there was an even distribution of those who had received absolute discharges, conditional discharges, or fines for simple possession. The same pattern emerged in those who admitted selling cannabis.

Ms Erickson concludes from this that the type of sentence given (for simple possession) had little bearing on the subjects' subsequent criminal activity.

Overall she is of the opinion that many of the social costs incurred by the cannabis use offenders seem to be attached to criminalization per se "and thus are not capable of being moderated by the theoretically less stigmatizing sentence of discharge.

"Efforts at law reform in the area of cannabis possession might be more realistically directed to the first component of criminalization — the number of criminals produced."

Anti-smokers must stress the short term benefits

AUCKLAND, NZ — Anyone trying to stop young people from smoking should emphasize the short-term benefits of not smoking, says David R. Hay, a New Zealand cardiologist.

It is not difficult to persuade heart and chest patients to stop smoking, he wrote in a medical journal article. The real problem is to reach the masses of young people who seldom see doctors.

Dr Hay believes young people are more likely to be impressed by messages relating to breath, smell, or taste; by demonstrations of better fitness and athletic performance, particularly if endorsed by celebrities; by appeals to their sexual image or manliness; by emphasis on pollution, personal environment and clean air; and, not least, by financial arguments.

Ottawa smoke ban has implications

(from page 1)

smokers did take heart in the fact the regulations would be next to impossible to enforce, even with the Green Hornets. And they often described the regulations as 99% politicking (there's a municipal election this month).

Yet, despite the possibility of legal complications and difficult enforcement, the legal sod-breaking by the city of Ottawa promises to have at least two important ramifications: it should convince legislators in other jurisdictions that the time is ripe for action of their own; and, perhaps more important, it should reinforce and perhaps amplify the growing activity within society to restrict smoking where it affects others detrimentally.

The controversy over the regulations has already triggered an enhanced consciousness among both smokers and non-smokers in this government town. More non-smokers are hesitating less about asking smokers to "butt out". And smokers increasingly are asking whether people they are with mind smoke.

Of course, criticism concerning possible infringement of personal rights has surfaced with a vengeance. One letter to the editor of an Ottawa newspaper complained it wasn't smoke that was a bother, but certain ingredients of salad dressings and other foods used in restaurants which sparked a reaction. So why not ban their use as well?

The non-smoking regulations originated with the Non-Smokers Association of Ottawa-Carleton. And despite opposition from all city department heads, the motion on the regulations passed city council with only two dissenting votes (both on the basis that the regulations would be impossible to enforce).

One Ottawa alderman who had complained about giving non-smokers "vigilante power" voted for the motion mistakenly during some of the confusion.

Fines on conviction of violating the new by-law range from $25 to $1000.

City Council also agreed to have the Green Hornets press charges after complaints had been made by private citizens.

Previously, smoking was prohibited only in retail stores with more than 25 employees and in areas designated for safety reasons by the fire marshall.

Under the new by-law, no-smoking signs will be popping up all over the city. The by-law says that "no person shall smoke in any retail shop except in a part used as a restaurant, lunch counter, hair dressing parlor, barber shop, rest room, or a part used as offices by members of the staff".

It also extends to hospitals, in patient care areas, though patients may still be allowed to smoke with written permission from their doctor.

It also covers taxis, where either the driver or the passenger may request the other not to smoke and may lay a complaint if refused.

The by-law also seems to cover those places where members of the public have to wait in line, such as at cash registers.

More Letters...

from page 9

Seemingly harmless caricature is detrimental

(from page 9)

this type of seemingly harmless caricature of a proud group of people is, in the strongest of terms, not appreciated!

In a sense, I am disappointed that an intelligent and aware staff such as yours would permit this poster to be published, let alone be placed in public.

You are no doubt aware there are many myths and stereotypes regarding all phases of the drug culture. Many of these are detrimental to the ongoing public education and information efforts that your publication carries out. Likewise, we as a group of people of Mexican descent find it just as difficult to educate and inform the public of the immesne harm that its negative myths and stereotypes creates.

I hope in future you will be more than diligent when selecting posters and/or photographs for **The Journal** and that you will assume the responsibility to see that an entire culture suffers no further harm as a result of ignorance on the part of you and your staff.

Leonard Adame
Recreational Drug Counsellor
Alcohol & Drug Information & Service Center for Kings County
Hanford, California

Maybe yes... ...maybe no

To the Editor:
The Rand Report (**The Journal**, August) deals with an unknown concept. An easy answer does not exist; try something new. If it may work, it may work.

Jim Newman
Alcoholism Coordinator
Adult Probation and Parole
Yakima, Washington

Interesting

To the Editor:

I have just finished reading your newspaper and found it very interesting. It had many features in it that caught my attention and I just had to read it. I also found out that I could subscribe to **The Journal** and that there is *no charge to Ontario residents*. Therefore, I would like to subscribe. Thank you very much.

George Chodan Jr
Timmins, Ontario P4N 6N6

Is this your own personal copy of The Journal?

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The Journal, published by the world-renowned Addiction Research Foundation of Ontario, is the international newspaper in the field of alcoholism and drug dependence. Each month, and more than ever, people in this field — doctors, lawyers, teachers, nurses, social workers, policemen, government officials, even private citizens — are turning to The Journal to keep in touch with what's happening.

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As the field of addictions has broadened, so has The Journal's coverage widened. The Backgrounder has been added for readers who want to know the finer details behind some of the major news stories. The increasingly popular Back Page always highlights one particular topic or event. And, the Coming Events column is now a must for people who want to make conference plans.

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If the content of The Journal has improved, so has its "look". A staid image doesn't imply accuracy or respectability any more than verbosity implies insight.
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We get letters

"The Journal sets a pattern which will become the sine qua non of good journalism in this field."
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Addiction Research and Treatment Corporation
Brooklyn, New York

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Surrey Hills, Australia

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CUT THIS ONE AND MAIL

New Books

by RON HALL

Responsible Drinking and Other Myths

. . . by Bob Hickle

During this period of expanding treatment and research into the problems associated with alcoholism, this book is intended to focus on the alcoholic. The material was gleaned from attending many Alcoholics Anonymous meetings and covers such topic areas as: reasons for drinking, decisions to quit and to drink, loneliness, the recovering wife, and the AA program. The author feels the alcoholic has a low tolerance for psychic pain and learns that alcohol alleviates that pain. When the pain caused by the use of alcohol becomes greater than the pain it numbs, its use becomes counter-productive. The insulated alcoholic is protected by some unique environmental condition such as money, position, family, and the nature of his job — literally protected to death. He concludes by considering that the social drinker and the alcoholic both use alcohol to fulfill unmet needs.

(Graphic Publishing Company, 1307 2nd Avenue SW, Waverly, Iowa, 50677. 1976. 40p. $2.)

Understanding Alcoholism

. . . by Leclair Bissell

This booklet presents a general overview of aspects of alcoholism including; identification, causes, diagnosis, cures, and living with an alcoholic. The stages of alcoholism are presented using the National Council on Alcoholism's self-examination checklist, and total abstinence is the goal of treatment. The author recommends Alcoholics Anonymous as a successful treatment approach and maintains that the primary goal of the family member should not be to stop the alcoholic's drinking, but rather to get him into treatment.

(Claretian Publications, 221 West Madison Street, Chicago, Illinois, 60606. 1973. 40 p. 95¢.)

Alcoholism and Addiction: A Study Program for Adults and Youth

. . . by Karl A. Schneider

This study program, complete with a filmstrip illustrating suggested topics for discussion through the use of charts and graphics, is intended to educate the participants in some of the causes, treatments, and prevention of alcoholism. The four-session program includes assignments, as well as readings and audio-visual aids. The author also provides suggestions for congregational cooperation with community and state agencies that deal with alcoholics.

(Fortress Press, 2900 Queen Lane, Philadelphia, Pennsylvania, 19129. 1976. 48p. $3.50.)

Other Books

Drug Misuse . . . Human Abuse — Green, Helen L., and Levy, Michael H. Marcel Dekker Inc., New York, 1976. Problems of misuse, facts about drugs, tables, appendices. 566p. $22.75.

Cannabis and Health — Graham, J. D. P. (ed). Academic Press, New York, 1976. Actions and effects on health, cannabis and society, appendix, indices, 481 p. $40.45.

Drink to your Health: Alcohol without Alcoholism — Adams, Junius. Harper and Row Publishers Inc., New York, 1976. Bibliography, index, 141p. $10.45.

Alcohol: Use, Nonuse and Abuse — Carroll, Charles R. Wm. C. Brown Company, Publishers, Dubuque, 1975. Second edition, alcohol problems, use and nonuse of beverage alcohol, alcoholic beverages, alcohol in the body, abuse of alcohol, references, index. 84p.

Alcohol Dependence and Smoking Behaviour — Edwards, Griffith, Russell, M. A. H., Hawks, David, and MacCafferty, Maxine (eds). D. C. Heath and Company, Lexington, 1976. Surveys of drinking behavior, hospital treatment, community, smoking studies, research, references, bibliography, index. 268p. $17.50.

The Treatment of Alcoholism: Theory, Practice and Evaluation — Larkin, E. J. Addiction Research Foundation, Toronto, 1976. Second edition; causes and cures, disease concept, treatment programs, termination of psychotherapy, behavior modification, program evaluation, tables, figures, appendices, references, indices. 101p. $2.95.

Teen-age Alcoholism — Haskings, Jim. Hawthorn Books Inc., New York, 1976. Facts and misconceptions about alcoholism, use and abuse of alcohol, alcohol and the body, alcohol and the mind, appendices, bibliography, index. 156p. $3.50.

The Long Suffering — Terry, Ronald. Paulist Press, Toronto, 1976. 77p. $4.55.

Responsible Drinking and Other Myths — Hickle, Bob. Graphic Publishing Company, Lake Mills, 1976. 40p. $2.

Drug Abuse Prevention: The Awareness, Experience, and Opinions of Junior and Senior High School Students in New York State — Dembo, Richard, Schmeidler, James, Lipton, Douglas, S., and Babst, Dean V. Bureau of Social Science Research and Program Evaluation, New York State Office of Drug Abuse Services, Albany, 1976. 33p.

Proceedings: Seminar on Health Services and Public Inebriate — National Institute on Alcohol Abuse and Alcoholism, Rockville, 1975, 74p.

Alcohol and Other Drug Testing in Traffic Deaths: A report on Current Practices in Canada — Simpson, H. M. and Heayn, Bruce. Traffic Injury Research Foundation of Canada, Ottawa, 1975. 30p.

Alcohol in Relation to Highway Safety — United States Department of Transportation, US Government Printing Office, Washington, 1975. 76p.

Drug Abuse: The Role of the Mayor — Mayors' Task Force on Drug Abuse Treatment and Prevention — National League of Cities and US Conference of Mayors, Washington, 1975. Organization, planning, treatment, personnel policy, training, community awareness, criminal justice. 129p.

Japanese report, solution for BC?

(from page 8)

addict in self reliance.

There are 225 counsellors who, with narcotic control officers and police, carry out the observation and guidance that follow hospitalization.

"Narcotic addicts retain a psychological desire for drugs even after they quit taking them and their character is weak in defending against various stresses," the report notes.

The Japanese report raises some questions.

What about all those people lost to the study? Why does each success with one drug seem to be followed by a wave of abuse of another? (Cited in addition to the current rising use of stimulants, is an ominous increase in the use of sleeping pills and tranquillizers.) Why is the number of narcotic offences still relatively high? What is the role of Japanese cultural traditions in the success of the psychological conditioning? What happened to the estimated 32,000 addicts who never came under the system? Why is the volume of heroin seizures as high now as in 1963?

But for all the quibbles, the results of the Japanese experiments have been both fascinating and impressive.

We can hope that the Canadian provincial health minister and alcohol and drug commissioner will go to that country with their critical faculties honed and return with insights that will lead to solutions for British Columbia.

Coming Events

In order to provide our readers with adequate notice of forthcoming events, please send announcements as early as possible to: The Journal, 33 Russell St., Toronto, Ontario, Canada, M5S 2S1, or telephone (416) 595-6053.

Canada

Detox Workers Training Program — Feb. 7-11 and March 7-11, 1977, Toronto, Ontario. Information: Diane Hobbs, coordinator, Detox and Rehabilitation Programs, 33 Russell St., Toronto, Ont., M5S 2S1.

Canadian Foundation on Alcohol and Drug Dependencies Annual Conference FUTURACTION — July 10-15, 1977, Winnipeg, Manitoba. Information: CFADD, 303 Kendall St., Vanier, Ontario.

US

Women in Distress — Nov. 30, Dec. 1 and 2, 1976, New York, New York. Information: Odyssey House, 309-311 East 6th St., New York, NY, 10003.

National Organization for the Reform of the Marijuana Laws annual meeting — Dec 10-12, 1976, Washington DC. Information: NORML, 2317 M St NW, Washington, DC, 20037.

Recovered Alcoholics in the Professions — Dec. 16-19, 1976, New York, New York. Information: National Association of Recovered Alcoholics in the Professions, PO Box 95, Staten Island, NY, 10305.

3rd Annual Research Meeting: Alcoholism The Search for the Sources — Jan. 26-28, 1977, Research Triangle Park, North Carolina. Information: Center for Alcohol Studies, Medical Building 207-H, Chapel Hill NC, 27514.

National Drug Abuse Conference 1977 — May 5-9, 1977, San Francisco, California. Information: NDAC-1977, Haight-Ashbury Training and Education Project, 409 Clayton, San Francisco, Cal, 94117.

Abroad

7th International Conference on Alcohol, Drugs and Traffic Safety — Jan. 23-28, 1977, Melbourne, Australia. Information: International Council on Alcohol and Addictions' Case Postale 140, 1001 Lausanne, Switzerland.

Cruising Medical Seminar on Alcoholism — Feb. 26 - March 5, 1977, Carribean cruise aboard Cunard Countess. Information: Center for Alcohol Studies, Medical Building, 207-H, Chapel, Hill, North Carolina, 27514.

6th International Conference of the World Union of Organization for the Safeguard of Youth — May 31 - June 4, 1977, Geneva, Switzerland. Information: World Union of Organizations for the Safeguard of Youth, 28 Place Saint-Georges, F-75442, Paris, Cedex 09, France.

23rd International Institute on the Prevention and Treatment of Alcoholism — June 6-10, 1977, Dresden, German Democratic Republic. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

7th International Institute on the Prevention and Treatment of Drug Dependence — June 13-15, 1977, Dresden, German Democratic Republic. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

1st International Conference of Social Pharmacology — June, 1977, Jerusalem, Israel. Information: Stanley Epstein, 113/41 East Taipiot, Jerusalem, Israel.

International Medical Symposium on Alcohol and Drug Dependence — Aug. 21-26, 1977, Tokyo and Kyoto, Japan. Information: ICAA, Case Postale 140, 1001 Lausanne, Switzerland.

Positions Available

Doctorate in counselling or clinical psychology to join small **CMHC** of 30 clinical staff. Lead program for substance abusers. Community is clean and stable. Lima is 55,000; with many smaller cities in three county catchment area. Salary negotiable and competitive. **Contact George E. North, Ph.D., Director, Northwest CMHC, Lima, Ohio 45801.**

The Child as Target

Editor's note: There is increasing concern among some experts that there may be a link between alcoholism and child abuse.

John Shaughnessy reports.

PETER is a two-year-old. His father, an alcoholic, beats Peter's mother. Later in the day, she beats Peter to stop him from crying.

• Or, Peter's father is an alcoholic who, when he gets drunk, beats the little boy.

• Or, Peter's mother is a single parent who falls into a drunken sleep each evening. Her boyfriend can't stand the child's antics so he slaps him around. And the boyfriend is a big man.

• Or, Peter's mother and father drink for several hours and then fall asleep leaving Peter unattended for long periods of time.

• Or, Peter's mother and father simply abuse Peter. They do not abuse alcohol but they both grew up in very unstable homes and both had at least one parent who was an alcoholic.

The situations are all easily imaginable. In how many of them is alcohol abuse related to child abuse?

One accepted theory suggests alcoholism is not a significant factor in child abuse. But some researchers think it is and believe further study is warranted.

People in both of these groups, and others outside of them, believe to draw such an association is dangerous. After all, they rightly point out, people who never touch alcohol beat their children.

Indeed, what is child abuse? Increasingly, the concept shifts.

Originally, it meant battering children and studies indicated alcoholism was, at best, only one of a myriad of causative factors. At the same time, treatment of alcoholism focussed on the alcoholic and little if any attention was paid to his or her family.

Now, gradually, the term child abuse is expanding to include emotional abuse and neglect. And in the alcohol field, workers are looking more at families.

At both levels, there is a growing awareness if not of a link between alcoholism and child abuse then at least of a need, as one social worker put, "to try and get it a little more sorted out. There may be a lot more kids out there who need help than we realize."

Mary Van Stolk would have agreed with that. But she wouldn't have agreed that alcohol was responsible. In her 1972 book, *The Battered Child in Canada*, she had this to say: "Alcoholism is not a major problem related to child abuse". Helfer and Kempe's book, *The Battered Child*, supports this statement.

In 1973, a controlled study of 214 parents of battered babies was conducted by the department of psychiatry at the University of Birmingham, England. The researchers concluded there was no association between alcoholism and child abuse.

The Ontario government's 1973 study of child abuse in Ontario, makes only a single comment about alcoholism and the abuser. "The elements in common for most of the reported cases were poverty and severe environmental stress, combined in a few cases with personality disorders and alcoholism."

Comments from those working at the treatment level give the same impression. Social workers all know of cases where alcohol abuse and child abuse are present in the same family, but the overall impression is that the association is not significant.

Dr Robert Bates, a pediatrician member of the Child Abuse Unit at Toronto's Hospital for Sick Children, echoes the social workers' sentiments. "Cases where the abusing party is drunk or an alcoholic are not common in my experience."

While acknowledging that people without alcohol problems can and do abuse children, however, the lack of association between alcohol abuse and child abuse seems suspect.

After four years of studying the parents of abused children, Dr Brandt Steele, from the University of Colorado School of Medicine, observed: "In all our patients who have attacked children, we have seen a breakdown in ability to mother. By 'mothering' (in both men and women) we mean the deep, sensitive, intuitive awareness of, and response to, the infant's condition and needs, as well as consideration of the infant's capacity to perform according to his age .... The parents are concentrating more on the needs they themselves have.

"What provokes child beating? An incredible sense of aloneness, worthlessness, and, strangely enough, desire — desire for the child to take care of the unheeded needs of the attackers own yesterdays."

The argument could be made that these traits fit alcoholics as well as child abusers.

And indeed there are studies refuting the claim that alcoholism is not a significant factor in child abuse.

In a 1971 French study, Mainard found alcoholism in 65% of the parents of 32 French children hospitalized following parental brutality. Alcoholism of the mother alone had led to negligence of feeding and cleaning of the children. Almost all the children involved were infants up to 30 months and more often were boys than girls. Another aspect of the same study, relating to social and legal problems of alcohol, indicated parental alcoholism was found in 90% of all cases of child abuse recorded in the juvenile court.

The study revealed that interrelationship between alcoholism and poverty, family circumstances, and occupational and emotional problems made it difficult to isolate alcoholism as the single factor responsible for child abuse. Nonetheless, the authors concluded that control of alcoholism would be a valuable first step for the prevention of child abuse.

In 1967, a German study by Nau of 105 child abusers revealed that 57% of the men and 42% of the women were alcoholics. The study also revealed that 44% of the men and 23% of the women were under the influence of alcohol at the time of their abusive behavior.

Pospisil-Zarrcki and Turcin, in 1968, found that of 62 persons who were tried as abusers of minors, alcoholism was legally documented in 37 cases and clinically confirmed in 23 cases.

More recently, a study by Chris Mouzakitis, assistant professor, and Gisela Spieker, PhD, professor, in the graduate school of social work at the University of Arkansas, in Little Rock, suggests child abuse may be prevalent among families where there is at least one parent who is an alcoholic.

At the New Orleans meeting of the Alcohol and Drug Problems Association of North America last September, they said: "One can predict that alcohol abusers could be potential child abusers. In fact, it might be said that as the alcohol abuser increases his drinking, he is more likely to become a child abuser."

The Little Rock researchers based their opinion on a study of 80 subjects in the Mid-South Center on Alcohol Problems. Referrals to this agency are made primarily from the court system and involve "driving while intoxicated" offences.

Of the 80 subjects, 42 had contact with or were responsible for children. Thirty-three percent of these 42 were classified as slight problem drinkers, 43% as moderate problem drinkers, and 24% as severe problem drinkers.

Further analysis of the 42 alcohol abusers (mostly men) showed that 52% were also child abusers, and all of those had moderate or severe drinking problems.

Neglect was the form of abuse suffered by 77% of the children and 23% were physically abused. More specifically, neglect was classified as: exposure to drinking and immoral environment (59%); lack of supervision (23%); improper sleeping arrangements (12%); and malnutrition (6%). Of the five children who were physically abused, there was one case of sexual molestation and the rest were "severe beatings".

The finding that neglect is the most common form of abuse coincides with the conclusions of researchers at the Washingtonian Center for Addictions in Boston who are currently studying the child rearing practices of alcoholic and drug addicted parents.

Drs Joseph Mayer and Rebecca Black note that many alcoholic fathers avoid the possibility of child abuse by making a conscious decision to refrain from physically disciplining their children while drinking. The wives rather than the children, often become the victims of their husbands' physical abuse while the children are more likely to suffer from emotional neglect by either parent.

In their study, the Boston researchers found "considerable evidence of the occurrence of emotional neglect and inconsistency of care". Alcoholic parents

often reported total withdrawal from their children during drinking. In addition there is extreme inconsistency in the amount of attention given to the children as well as in the amount of care and discipline.

There have been few instances of physical neglect in the cases studied so far. But the researchers point out that physical neglect is more likely to occur in cases in which the mother or both parents are alcoholics.

The University of Arkansas researchers, Chris Mouzakitis and Gisela Spieker, do not disagree that abusive and neglectful behavior by parents can be understood and described in psychological terms. But they contend that such behavior can also be etiologically understood and treated as being the result of alcohol abuse.

Further, they say children of alcoholic parents very rarely come to the attention of social agencies even where the parent's alcoholic condition may be known to such agencies.

"It is ironic, to say the least, with a known alcoholic population in the United States of approximately 9 million adults, of whom 4.5 million are said to have responsibility for the care of children, provision for their care has not been made.

"If the findings of our study are applied to the overall population of alcoholics with children, would that mean about 25% or 2,250,000 of them are potential or actual child abusive and neglectful parents?"

Prevention of child abuse and neglect, they add, is an inseparable part of child welfare philosophy but it must also be considered by those who have initial contacts with alcohol abusers, such as the courts, in making referrals to treatment agencies. "The fact that services are offered to the alcohol abuser is not enough; demands for increased services on behalf of the child of alcoholic parents must be made."

In Canada, the demands even if made would likely go unheard. Federal Health Minister Marc Lalonde estimates that 700,000 of Canada's 12 million drinkers are alcoholics. Last year there may have been as many as 8,700 cases of battered children, with unknown numbers suffering abuse by neglect. Data attempting to link the two appear non-existent, or at least go unpublicized. And as Dr Robert Bates says "until we prove a need we won't get money for treatment or research."

He thinks the Children's Aid Societies could do more in the way of writing up cases and publishing reports on the whole problem of child abuse. CAS social workers agree that in Canada there has been little in the way of compiling profiles from individual case files.

Catherine Maclean, assistant to the coordinator of the Child Abuse Program sponsored by Ontario's Ministry of Community and Social Services, stresses that child abuse must be approached on a multi-disciplinary level.

At this stage, she says, the government conducts demonstration projects, helps plan regional seminars for groups dealing with the problem, and is attempting to determine specific training needs for different groups associated with child abuse such as police and social workers.

"We know the link between alcohol abuse and child abuse is there. There are certainly many cases of child abuse provoked by addiction of one sort or another, but we don't know the extent of it.

"We'd welcome any input we could get from researchers in the alcoholism field. We hope they are alert to the possibility of child abuse, and they should be able to make a valuable contribution to our multi-disciplinary approach."

One such valuable contribution came from R. Margaret Cork, formerly head of the Addiction Research Foundation of Ontario's Youth Counselling Service in Toronto. In her 1969 book, *The Forgotten Children*, she describes her study of 115 children who had one or both parents as alcoholics.

The children ranged in age from 10-16 years, and quotes from the children interviewed perhaps best illustrate the effects of their parents' alcoholism.

"I don't go places with my friends and their parents because I can't ever take my friends places."

"Everybody at our house is angry all the time."

"I worry all afternoon at school about how things will be when I get home."

"The kids at school all talk about the fun they have with their families. It makes me feel sort of left out."

"I can take it when one of them drinks, but I really get scared when they both start."

"Mom doesn't look after us. I have to be the mother myself."

"Why did they have us at all if they weren't going to care about us?"

"She could be different. She doesn't need to fight with him or nag us, even if he is drinking."

Some would say these quotes are not indicative of child abuse per se. Perhaps they should ask the children.

In any event, they do point up the heavy burdens forced on the children of alcoholics, and make clear the need for concern and treatment of them.

Reesa Kassirer, a social worker and family therapist at the Central Branch of the Addiction Research Foundation in Toronto, adds a note of caution. She says it's dangerous to link alcohol abuse with child abuse (neglect) if the implication is that to cure the alcohol abuse is to cure the child abuse.

"Alcoholism is a family system problem, not a one person problem. Alcoholics and those in their family often feel inadequate as human beings. As their responsibilities increase they fear that they can't cope, and their drinking increases as a result.

"What we really need is a vehicle to teach people to feel better about themselves so they won't use or abuse others."

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